FISCAL YEAR 1988 BUDGET RECONCILIATION ISSUES RELATING TO HOSPITAL PAYMENTS UNDER THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

APRIL 1, 1987

Serial 100-21

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

76-783 WASHINGTON : 1987

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

1281-11

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FISCAL YEAR 1988 BUDGET RECONCILIATION ISSUES RELATING TO HOSPITAL PAYMENTS UNDER THE MEDICARE PROGRAM

WEDNESDAY, APRIL 1, 1987

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:35 a.m., in room 1100, Longworth House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
MONDAY, MARCH 23, 1987

PRESS RELEASE #9
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1114 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
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THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON FISCAL YEAR 1988 BUDGET RECONCILIATION ISSUES RELATING TO HOSPITAL PAYMENT UNDER THE MEDICARE PROGRAM, INCLUDING THE MEDICARE HOSPITAL PROSPECTIVE PAYMENT UPDATE FACTOR, TO BE HELD ON WEDNESDAY, APRIL 1, 1987

The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on Fiscal Year 1988 budget reconciliation issues relating to hospital payment under the Medicare program, including the Medicare hospital prospective

payment update factor. The hearing will be held on Wednesday, April 1, 1987, beginning at 9:30 a.m., in room 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark stated, "Our goal in setting hospital payment levels is to assure equity among hospitals, beneficiaries, and the Medicare program. Our need to achieve savings must always be balanced against the needs of beneficiaries and the necessity of paying hospitals fairly for their services."

The April 1 hearing will include testimony from William Roper, M.D., Administrator of the Health Care Financing Administration, Stuart Altman, Ph.D., Chairman of the Prospective Payment Assessment Commission (ProPAC), and Carol McCarthy, Ph.D., J.D., President of the American Hospital Association.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

Background

The prospective payment system (PPS) was adopted in 1983 as the method of hospital payment for Medicare. Hospitals are paid a prospectively determined amount per patient stay based upon diagnosis related groups (DRGs). The DRG payments are updated yearly based upon changes in the hospital market basket, an index of the price of the goods and services purchased by hospitals, and other factors, including new technology, productivity, site-of-care, and coding of diagnostic information.

The Secretary of Health and Human Services is required to recommend an update in DRG payments for FY 1988 by April 1, 1987, both for PPS and PPS-exempt hospitals. ProPAC is also required to recommend an appropriate percentage change by April 1.

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, April 24, 1987, to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE ENCLOSED FORMATTING REQUIREMENTS

*****

Chairman STARK. The Health Subcommittee of the Ways and Means Committee will continue its consideration of hospital payment issues raised by the 1988 budget reconciliation legislation.

We are pleased this morning to welcome Dr. Bill Roper, Administrator of the Health Care Financing Administration; Dr. Stuart Altman, Chairman of the Prospective Payment Assessment Commission; and Dr. Carol McCarthy, president of the American Hospital Association. Their expertise should prove most helpful to the subcommittee in examining the hospital payment issues.

We will receive today the Secretary's report to the Congress on his recommendations regarding the fiscal year 1988 update factor for hospital payment rates. In addition, we will have the benefit of the recommendations of ProPAC regarding a number of issues affecting hospital payment.

The task before the subcommittee, and ultimately the Congress as a whole, is to determine a reasonable and appropriate level of payment to hospitals under the Medicare program in fiscal year 1988.

We need to carefully examine the issue of hospital margins. Our analysis of 1984 hospital cost data, recently made available, indicates that the system produced average DRG margins of approximately 12 percent in 1984.

About this number there is little argument. Where there is a great deal of disagreement is about how the system should be adjusted to react to this new information.

Clearly some adjustment is appropriate, given the role of inaccurate data and faulty assumptions in explaining the margin.

We need better and more up-to-date information. Arguing year after year over different estimates of what the numbers really are makes little sense.

I might add here that I have talked with my ranking member, Mr. Gradison, and we both would like to see some kind of current reporting on a standard chart of accounts, electronically collated and made available on a current basis to all parties at interest with the proper safeguards for confidentiality because we would like these reports to include income data. And it seems to us often to be an exercise in futility to try and determine procedures or make decisions which should be made empirically where the data exists, and we just cannot get at it. It is both bad for the medical community, the administration, and the Congress.

A payment system of this magnitude requires a modern management information system. And there is no other way to make rational and fair decisions. We hope to put this numbers debate to rest.

I would like to thank our witnesses for appearing today. I look forward to their testimony. I particularly want to thank Dr. Roper and his staff for their quick response to a California problem of possible dumping. There must be a better word for that. I think this quick response explains to the hospital community at large, that HCFA does intend to take seriously the prohibition on discharging unstable patients through emergency room situations, whether or not they are Medicare beneficiaries. It should apply to all citizens. And once it is understood by the medical community that we intend to enforce it vigorously, this practice, which no one

approves of, will cease. And I want to thank you, Bill, for taking such quick action.

I must add that it hurts. It is in my neighborhood, and it may dispossess many of the poorest in our area. I think we will determine where the fault lies, and with HCFA's continued help, be able to correct it. But you take the bitter with the sweet.

Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman. I too want to join in welcoming the witnesses. And I want to associate myself with your remarks with regard to the need for better data and more timely data.

Lacking data, this member, for one, is going to lean in the direction of higher payments, lest we do harm to the system, and I think the risks of harm to the system are greater by making too small payments rather than too large. And that is not directed at anybody in particular. But I think it does suggest that those who counsel us to give greater discretion with respect to the setting of updates to the administration, or suggest lower figures than the statute now calls for, will help their cause if they can assist us in getting more comprehensive data.

I have been meeting with a lot of hospital people from States other than my own, as well as from my own State recently. And the thing that comes through to me is the number who indicate that they are currently running in the red, and that their ability to carry out their mission is in doubt if we keep going in the direction that we are going in. That gives me a great deal of concern.

Thank you, Mr. Chairman.

Chairman STARK. The statements of the witnesses, without objection, will appear in the record in their entirety. And it is not the Chair's intention to limit the witnesses' time in any way.

But the committee would welcome their expansion on their testimony, any summaries or additional observations they would care to make. So, welcome back, Dr. Roper. Proceed in any manner you are comfortable.

STATEMENT OF WILLIAM L. ROPER, M.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. ROPER. Thank you, Mr. Chairman, members of the committee.

I am glad to be before you today and I appreciate the opportunity to discuss the applicable prospective payment system percentage increase in fiscal year 1988 Medicare payments to hospitals.

As Secretary Bowen has indicated in a letter to the House and the Senate today, we believe, based on preliminary data and analyses available at this time, that the applicable percentage increase of 1½ percent envisioned in the President's 1988 budget may be too low, and that the appropriate increase could range as high as 2 percent. However, we believe a final recommendation should be deferred until nearer the beginning of the fiscal year, when more recent data and complete analysis will be available to develop an equitable and realistic update.

In regard to exempt hospitals and units, we currently believe that the appropriate update for the target rate of increase could range as high as 4 percent, and we will come forward with a final recommendation on that point as well.

Let me discuss a bit of background. For each year since fiscal year 1985, the Secretary has been required to determine the annual rate of increase in payments to PPS hospitals by taking various factors into account, including ProPAC's recommendations. Under the first 2 years of PPS, these payments were required to be budget neutral to the TEFRA provisions.

Even in the face of budget neutrality, hospitals appeared generally to have fared quite well in the early years of PPS. Urban hospitals did particularly well, on average, experiencing operating margins about twice those of rural hospitals. This disparity between urban and rural hospitals has been commented on a great deal, and it was the impetus for the Congress to take several steps in OBRA-86 to increase payments for rural hospitals relative to urban hospitals.

First, that bill mandated separate outlier reductions to the PPS rates of urban and rural hospitals.

Second, it provides for future discharge weighting of payment rates, rather than hospital weighting of those rates, giving greater weight to the cost experience of larger hospitals.

The combined effect of these two changes will be to increase the payment rate of rural hospitals by about 6 percent, while reducing urban rates by less than 1 percent. Thus, the differential between rurals and urbans is narrowing.

Another recent change will enable an estimated 60 additional rural facilities to qualify as rural referral centers and be paid at the urban rate.

We are quite aware, of course, that ProPAC now has proposed an adjustment in the PPS rates which favors rural hospitals relative to urban hospitals. We share their interest in preserving access to quality health care services in rural America and have given consideration to such a step. But based on the data and analysis available at this time, and before we have completed a full analysis of ProPAC's recommendations, the cumulative effect of changes enacted in OBRA-86 suggests that a higher applicable percentage increase for rural hospitals is not now justified. While OBRA-86 changes will improve the equity of the system, our analysis indicates that these effects, in conjunction with higher fiscal year 1988 increases for rural hospitals than for urban hospitals, could produce a payment system which would overcompensate rural hospitals.

Although recent congressional action appears to have improved the equity in payments for urban and rural hospitals, the issue of the overall profitability of hospitals under PPS remains. HCFA, the HHS Inspector General, ProPAC and CBO have all done analyses showing that Medicare payments exceeded hospital costs by 12 to 16 percent in the first year of PPS, fiscal year 1984. The Inspector General has found similar margins persisting into fiscal year 1985 for at least a statistically representative sample of hospitals.

The high operating margins observed in the first 2 years of PPS appear to be due, in part, to prospective payment rates being set

too high from the outset, based, as they were, on unaudited cost data. These high operating margins for Medicare also stem from the success of PPS in getting hospitals to change their behavior, particularly with respect to reducing length of stay and furnishing certain services in less costly settings. That some 80 percent of hospitals experienced positive Medicare operating margins during the first 2 years of PPS is, in large measure, evidence of the adaptability of hospitals.

To some extent, though, the magnitude of the margins is a testimony to Congress awarding higher updates than we would have viewed as prudent. In fiscal year 1986, for example, we recommended a freeze as the most reasonable policy. Instead, Congress chose to provide an applicable percentage increase of half a percent. Last year, in response to our recommendation of a half percent increase, Congress chose to provide an increase of 1.15 percent. Moreover, for fiscal year 1988, Congress has mandated an increase of the market basket less 2 percent, which would be 2.9 percent.

Since the start of PPS, we have seen Medicare's share of hospital revenues increase until in fiscal year 1985, for the first time, Medicare's share of hospital revenues exceeded its share of hospital days. During fiscal years 1984 to 1986, Medicare payments per admission increased more rapidly, after adjusting for inflation and hospital input prices, than they did in the period from fiscal years 1979 to 1983. In sum, it is no surprise that hospitals fared well, on average, during the early years of PPS.

But in fiscal year 1987, however, we are modestly increasing Medicare payments per admission in sharp contrast to the rapid rates of growth in fiscal years 1984 and 1985. As I will explain in a moment, Medicare payments per admission, after adjusting for inflation, a key point, may decline in fiscal year 1987. We believe that we are now just starting to tighten the system. If maintained, this trend will ultimately begin to reduce the high margins of the early PPS years, assuming that hospitals do not continue to adapt their practice patterns and improve their efficiency.

Based on the most recently available data, we believe we should continue on the same general course for fiscal year 1988 as over the last two years. That is, PPS rates should be increased modestly, but the increase should be substantially less than the forecasted increase in the hospital market basket. In this way, financial dislocation in the hospital industry is avoided while, at the same time, the Medicare program continues to benefit from the changes in hospital behavior that have resulted from prospective payments.

The most important change since the President's budget was prepared is the fact that the increase in reported case mix has stopped, at least temporarily. Data from early 1986 to the present show no increase in case mix. We will continue to monitor this surprising development. Case mix changes are comprised of two components: real case mix changes and coding creep. In the past, hospitals have benefitted from changes in their DRG coding practices, coding cases into DRGs with higher payments without experiencing higher costs. If the trend of no observed case mix change continues, it may mean that hospitals are no longer benefitting financially from changes in DRG coding practices. On the other hand, no observed case mix increase may mean that hospitals have experi-

enced a drop in real case mix and, at the same time, are continuing to code cases as more complex, generating a financial bonus for themselves. We will continue to monitor the data on this point.

If hospitals are at least temporarily no longer benefitting from changes in coding practices, the PPS system is becoming more stringent in fiscal year 1987 than in the system's early years, especially since there have been significant legislative changes in Medicare payments for medical education and capital. Consequently, we estimate that inflation-adjusted payments per case will fall more than 3.5 percent in fiscal year 1987 compared to fiscal year 1986.

We believe that the reduction in inflation-adjusted payments per case in fiscal years 1987 and 1988 are justified based on the available evidence of hospital profits under PPS. However, we favor a policy of gradually tightening the PPS rates rather than dramatic reductions. Hospitals may be losing some, though by no means all, of their ability to respond to low update factors by cutting their costs.

Two factors seem particularly relevant to Medicare prospective payment:

The decline in the average length of stay has stopped, at least temporarily. After declining about 18 percent in the early years of PPS, the average stay actually increased slightly in the most recent data.

During fiscal years 1987 and 1988, hospitals will be adjusting to reductions in Medicare payments for medical education and slowed growth rates for capital payments.

In addition, hospitals face other financial pressures beyond the Medicare program.

For example, there are increasing reports that hospitals are having difficulty attracting and keeping qualified nurses. Hospitals may have to pay nurses more and increase their nurse to patient ratios.

Further, uncompensated care for non-Medicare patients is a growing burden on hospitals. AIDS and other high cost illnesses contribute to this problem.

In assessing the appropriate update factor for fiscal year 1988, Congress should consider the varying effects of PPS on different types of hospitals in different regions. We will soon be submitting a report to Congress on these variations. Although some of the variation is almost certainly due to differences in hospital efficiency, other factors may play a role—for example, the inability of the DRG system fully to account for differences in patient severity of illness.

Based on the most recently available data, we believe that the 1.5 percent increase in the PPS payment rates may be too low, and the appropriate update could range as high as 2 percent. We will make our final recommendation on the appropriate increase nearer the beginning of the new fiscal year, based on the latest estimates of relevant factors, including ProPAC's recommendations.

Finally, I would urge you, in light of this, to reexamine the issue of the Secretary's authority over the PPS update factor, and that you return to the Secretary the discretion that he and his predecessors have had to set the rate of increase for hospital payments. We are not, as some have alleged, interested in budget policy to the ex-

clusion of health policy, but rather in striking the proper balance between fiscal prudence and concern for the welfare of our beneficiaries.

In the past, the Secretary has recommended or set payment levels. The Congress in the past has overturned those recommendations. We would see that as the appropriate role of the Congress. And in the future, should the Secretary set rates that you find either too high or too low, we would urge that you leave him the authority to set the rates and keep for yourselves, of course, the authority to change those rates.

Thank you. I would be happy to answer your questions.

[The prepared statement follows:]

Statement of
WILLIAM L. ROPER, M.D.
Administrator, Health Care Financing Administration

I appreciate the opportunity to appear before you today to discuss the applicable PPS percentage increase in FY 1988 Medicare payments to hospitals. As Secretary Bowen indicated in a letter sent to you today, we believe, based on preliminary data and analysis available at this time, that the applicable percentage increase of 1.5 percent envisioned in the President's FY 1988 budget may be too low, and that the appropriate increase could range as high as 2.0 percent. However, we believe a final recommendation should be deferred until nearer the beginning of the fiscal year, when more recent data and complete analysis will be available to develop an equitable and realistic update.

In regard to exempt hospitals and units, we currently believe that the appropriate update for the target rate of increase could range as high as 4.0 percent. When we make our final recommendation for the PPS standardized amount, we will also update our estimates of the appropriate update for the target rate of increase based on more complete analysis.

I would briefly like to outline the reasons for the foregoing recommendation and to review the evolution of the program over the past few years.

BACKGROUND

For each year since FY 1985, the Secretary has been required to determine the annual rate of increase in payment rates to PPS hospitals by taking into account various factors affecting hospital costs, as well as the recommendations of the Prospective Payment Assessment Commission (ProPAC). Under the first two years of PPS, payments under the new system had to be budget neutral relative to the Tax Equity and Fiscal Responsibility Act of 1982.

As you are aware, even in the face of the budget neutrality requirement, hospitals appear to have generally fared quite well during the early years of PPS. Urban hospitals did particularly well, on average, experiencing operating margins about twice those of rural hospitals. This disparity between urban and rural hospitals was the impetus for Congress to enact in the Omnibus Budget Reconciliation Act of 1986 (OBRA-86) significant steps to increase payments for rural hospitals relative to urban hospitals.

First, OBRA-86 mandated separate outlier reductions to the PPS rates of urban and rural hospitals based on their differential outlier experience. Since rural hospitals typically experience fewer outlier cases than urban hospitals, the effect of this change is to increase rural rates relative to urban rates.

Second, OBRA-86 provides, effective for discharges in FY 1988, that the PPS rates be computed on a discharge-weighted rather than a hospital-weighted basis, thus giving greater weight to the cost experience of larger hospitals. Because large hospitals account for a larger proportion of all cases in rural areas than in urban areas, discharge-weighting increases payment to rural hospitals relative to urban hospitals.

The combined effect of these two changes will be to increase the payment rate of rural hospitals by about six percent while reducing urban rates by less than one percent. As a consequence, the discrepancy between rural and urban hospital operating margins will be almost eliminated.

Another recent change will enable an estimated 60 additional

rural facilities to qualify as rural referral centers and be paid at the urban rate.

We are, of course, aware that the Prospective Payment Assessment Commission has proposed an adjustment in the PPS rates which favors rural hospitals relative to urban hospitals. We share their interest in preserving access to quality health care in rural America and have given consideration to such a step. Based on data and analysis available at this time -- and before we have completed a full analysis of ProPAC's recommendations -- the cumulative effect of changes enacted in OBRA-86 suggests that a higher applicable percentage increase for rural hospitals is not justified. While OBRA-86 changes will improve the equity of the system, our analyses indicate that their effect, in conjunction with a higher FY 1988 increase for rural hospitals than for urban hospitals, could be to produce a payment system which would over-compensate rural hospitals.

Although recent congressional action appears to have improved the equity in payments for urban and rural hospitals, the issue of the overall profitability of hospitals under PPS remains. HCFA, the HHS Inspector General, ProPAC and CBO all have done analyses showing that Medicare payments exceeded hospital costs by 12 - 16 percent in FY 1984. The Inspector General has found similiar margins persisting into FY 1985 for at least a statistically representative sample of hospitals.

The high operating margins observed in the first two years of PPS appear to be due, in part, to prospective payment rates being set too high from the outset, based, as they were, on unaudited cost data. These high Medicare operating margins also stem from the success of PPS in getting hospitals to change their behavior, particularly with respect to reducing length of stay and furnishing certain services in less costly settings. That some 80 percent of hospitals experienced positive Medicare operating margins during the first two years of PPS is, in large measure, evidence of the adaptability of hospitals.
To some extent, though, the magnitude of the margins is a testimony to Congress awarding higher updates that we would have viewed as prudent. For FY 1986, for example, we recommended a freeze as the most reasonable policy. Instead, Congress chose to provide an applicable percentage increase of half a percent. Last year, in response to our recommendation of half a percent increase, Congress chose to provide an increase of 1.15 percent. Moreover, for FY 1988, Congress mandated an applicable increase equal to the market-basket rate of increase less two percentage points, or 2.9 percent. This is almost a full percentage point higher than what we now believe to be the upper limit for the applicable percentage increase.

Since the start of PPS, we have seen Medicare's share of hospital revenues increase until in FY 1985, for the first time, Medicare's share of hospital revenues exceeded its share of hospital days. During FY 1984 to 1986, Medicare payments per admission increased more rapidly, after adjusting for inflation and hospital inputs, than they did in the period from FY 1979 to 1983. It is, therefore, no surprise that hospitals fared well, on average, during the early PPS years.

In FY 1987, however, we are modestly increasing Medicare payments per admission, in sharp contrast to the rapid rates of growth in FY 1984 and FY 1985. As I will explain shortly, Medicare payments per admission, after adjusting for inflation in hospital inputs, may decline in FY 1987. We believe that we are now just starting to "tighten" the system. If maintained, this trend will ultimately begin to reduce the high margins of the early PPS years, assuming hospitals do not continue to adapt their practice patterns and improve their efficiency.

With this background, let me discuss our rationale for our FY 1988 recommendation.

UPDATE RECOMMENDATION

Based on the most recent available data, and currently available but preliminary analysis, we believe we should continue on the same general course for FY 1988 as over the last two years. That is, the PPS rates should be increased modestly, but the increase should be substantially less than the forecasted increase in the hospital market basket. In this way, financial dislocation in the hospital industry is avoided, while at the same time the Medicare program continues to benefit from the changes in hospital behavior that have resulted from PPS.

The most important change since the President's FY 1988 budget was prepared is the fact that the increase in reported case mix has stopped, at least temporarily. Data from early 1986 to the present show no increase in case mix. We will continue to monitor this surprising development. Casemix changes are comprised of two components, real casemix changes and coding creep. In the past, hospitals have benefitted from changes in their DRG coding practices -- coding cases into DRGs with higher payments without experiencing higher costs. If the trend of no observed casemix change continues, it may mean hospitals are no longer benefitting financially from changes in DRG coding practices. On the other hand, no observed casemix increase may mean that hospitals have experienced a drop in real casemix (reducing their true costs) and at the same time are continuing to code cases as more complex, generating a financing "bonus" for themselves. We plan to further analyze the data and determine whether hospitals still reap a "bonus."

If hospitals are at least temporarily no longer benefitting from changes in coding practices, the PPS system is becoming more stringent in FY 1987 than in the system's early years, especially since there have been significant legislative changes in Medicare payments for medical education and capital. Consequently, we estimate that inflation-adjusted payments per case will fall more than 3.5 percent in FY 1987 compared to FY 1986.

We believe that the reductions in inflation-adjusted payments per case in FY 1987 and FY 1988 are justified based on the available evidence of hospital profits under PPS. However, we favor a policy of gradually tightening the PPS rates rather than dramatic reductions. Hospitals may be losing some, though by no means all, of their ability to respond to low update factors by cutting their costs.

Two factors seem particularly relevant to Medicare prospective payment:

- The decline in the average length of stay has stopped, at least temporarily. After declining about 18 percent in the early years of PPS, the average stay actually increased slightly in the most recent data.

- During fiscal years 1987 and 1988, hospitals will be adjusting to reductions in Medicare payments for medical education and slowed growth rates for capital payments.

In addition, hospitals face other financial pressures as a part of their cost of doing business more generally;

- There are increasing reports that hospitals are having difficulty attracting and keeping qualified nurses, an essential ingredient for high-quality care, to all hospitalized patients not just Medicare beneficiaries. Hospitals may have to pay nurses more and increase their nurse-to-patient ratios in order to make careers in hospital nursing more attractive.

- Uncompensated care for non-Medicare patients is a growing burden on hospitals. AIDS and other high cost illnesses contribute to this problem.

In assessing an appropriate update factor for FY 1988, Congress should consider the varying effects of PPS on different types of hospitals in different regions. We will soon be submitting a report to Congress documenting these variations. Although some of the variation is almost certainly due to differences in hospital efficiency, other factors may play a role -- for example, the inability of the DRG system to fully account for differences in patient severity of illness.

CONCLUSION

Based on the most recent available data, we believe that the 1.5 percent increase in the PPS standardized amounts envisioned in the President's budget may be too low. Current data suggest that the appropriate increase in the standardized amounts could range as high as 2.0 percent.

This recommendation is contingent on current projections of relevant data. If current preliminary analysis were to change based on later data or more complete analysis, our recommendation for the applicable percentage increase would change correspondingly. We will make our final recommendation on the appropriate increase nearer the beginning of the new Federal fiscal year based on the latest estimates of all relevant factors, including ProPAC's recommendations.

In your consideration of the FY 1988 update over the coming months, I also ask that you reexamine the issue of the Secretary's authority over the PPS update factor and that you return to the Secretary the discretion to set the rates of increase for hospital payments. We are not, as some have alleged, interested in budget policy to the exclusion of health policy, but rather in the striking the proper balance between fiscal prudence and concern for the welfare of our beneficiaries.

Thank you. I would be happy to take your questions.

Chairman STARK. Doctor, giving the Secretary that authority makes good sense to me. And I think that as soon as the Secretary submits the reports to the Congress, that are 1 and 2 and 3 years late, and updates the accounts, we could have a hearing to determine whether or not he has the information to set the rates.

But right now, we are all trying to figure out which way the wind is blowing. And I do not think we are going to even consider relinquishing that authority until management information is current, and you can convince us that the information exists.

I am not suggesting for a minute that we have it, but as long as we are all guessing about what it ought to be, I guess we want to be the guessers. Now I would like to recognize my colleague, Congressman Russo, who is currently preparing the budget which this subcommittee will have to react to, but he had an inquiry along that line.

Congressman Russo.

Mr. RUSSO. Mr. Chairman, thank you very much.

As a member of the full committee, but not a member of the subcommittee, I want to thank my colleagues for allowing me to follow up on those comments you made.

Dr. Roper, in the Deficit Reduction Act of 1984, the committee mandated a report on further refinements to PPS, including recommendations on accounting for variations and costs per discharge within the DRGs. It also mandated a discussion on determining payment on a regional basis, which basically was the study that I asked be done. This study was due September 1, 1984.

Last year, when we were discussing this issue again, especially with Congressman Daub, who was incensed by the fact that we still had not had it. He assured me that with his contacts within the administration, that he would be able to have it done within timely fashion. So far, neither he nor I have received a copy of this report, and I know you have it. According to the committee's green book, all the reports and studies which you have been asked to prepare can sometimes be overburdening, but can you let me know when you think this particular report will be ready for the Hill so we can look at it? Because the way I see it in my area, the Midwestern hospitals are disproportionately disadvantaged by moving to this national rate. And obviously, I think some adjustments need to be made to make it fairer. Some hospitals in other regions are not benefiting to our detriment.

It is difficult for us to make legislative changes without having an official report other than what the hospitals in my district are telling me.

So, could you tell me when we can receive this report?

Dr. ROPER. We anticipate having it up to you either late this spring or early summer.

Mr. RUSSO. I appreciate that. Thank you very much. Thank you, Mr. Chairman and colleagues.

Chairman STARK. Doctor, I have just been handed our dilemma in hastily written notes. The House Budget Committee, these are the Democrats—I do not know whether this is an agreement—is recommending a $1.5 billion cut for fiscal year 1988. And the administration's budget is $4.76 billion, although that includes part B. And I believe that comes down—please forgive me if these num-

bers are somewhat off—$3.7 billion. So we are about $2.1 billion and change apart.

And it kind of breaks down to cutting a half a billion in the update, eight-tenths of a billion in the indirect medical and three-tenths in direct medical. This means $1.1 billion out of medical education; $1.2 billion out of it for disproportionate share, and another $900 million out of other prompt payments. So, in a sense, what we do in the prospective payment update is small potatoes to these other things. And with the disparity in our budget, I would suspect that is about all there is to cut. I mean we would not even begin to do direct medical education or any of the others.

Now, I also get a feeling here that there is a tremendous amount of doubling up on disproportionate share hospitals. This is where numbers become so important—numbers which we do not have. You and I could both be sitting here with our little computer and know the exact answer to this. But if you double up the indirect and direct medical and the disproportionate share, that is about $2.5 billion in your budget, I will bet you that two-thirds of that comes out of disproportionate share hospitals. And they all get lumped together.

Dr. ROPER. That assumes that all teaching hospitals are disproportionate share hospitals.

Chairman STARK. No. I am saying two-thirds. I am just making a guess. And we ought to know that. You see, I can say two-thirds and you can say only 30 percent but——

Dr. ROPER. That is a knowable figure.

Chairman STARK. Yes. But there is a number we could get to with our shoes and socks on if we had the numbers.

But my real question is, do you not suspect that these suggested cuts do double up in focus somewhat disproportionately, or are leveraged against the disproportionate share hospitals? When you add in teaching and disproportionate share and a cut in the PPS, are you not leveraging against the disproportionate share?

Dr. ROPER. No, I do not think so. I think the point has to be separated. The part of our savings in doing away with the periodic payments to disproportionate share hospitals is $1.2 billion, as you point out.

The most recent data that we have available is that these hospitals that are benefiting under the disproportionate share adjustment were not doing disproportionately worse than hospitals generally even before the disproportionate share adjustment was added on top of the amount that they are paid under the Medicare program.

Mr. GRADISON. Would the chairman yield?

Chairman STARK. I would be glad to.

Mr. GRADISON. Can you distinguish, in talking about disproportionate share hospitals, with regard to the results for teaching disproportionate share hospitals and nonteaching disproportionate share hospitals? Would your comment that you just made apply to both groups or primarily to the teaching ones?

Dr. ROPER. Primarily to the teaching ones. But the figures that I have seen as of yesterday also apply to the groups as a whole.

The other point is what is appropriate Federal policy with respect to graduate medical education? And although it is a separate

issue, it certainly touches similar hospitals, and in many cases the same hospitals. But it is a separate issue and strikes to the question of what the Federal role is in continuing to support graduate medical education. We believe that support is overly generous and needs to be cut back further.

Chairman STARK. Is it not, though, the case that the disproportionate share hospitals are the highest most——

Dr. ROPER. Worse off?

Chairman STARK. Worse off. Highest out of proportion.

Well, I gather that is how we got there. We just took the highest hospitals that were above what, 5 percent, something like that. Is that how we made the cut?

Dr. ROPER. You chose to continue the periodic payments for disproportionate share hospitals. The general point I would seek to make is I do not think we have a very good idea of which hospitals really are disproportionate share hospitals, and the crude attempts to circumscribe a group of hospitals have buried a number of hospitals in very different circumstances.

Chairman STARK. I want you to search your soul.

Do you not believe, as I believe, that somewhere in our great Federal bureaucracy, and I rather suspect it is up at OMB, we have that information and we know which hospitals need help, right to the gnat's eyebrow?

Dr. ROPER. If you are asking do we know hospital by hospital, with specificity such that it can be implemented in public policy, the answer is no.

We are trying to deal across the Medicare program. We have averages, large numbers of hospitals, and a point I hope we get to subsequently is that averages cover up as much as they reveal.

Chairman STARK. I could not agree more.

Let's talk a minute about our reporting system.

It is my understanding that HCFA had a system of uniform hospital reporting back in the seventies. I have been made aware of that. Does that old system, the chart of accounts, exist today? Is it around some place or are you aware of it?

Dr. ROPER. I would be glad to get you an answer.

[The following was subsequently received:]

Uniform hospital reporting, based on a standardized chart of accounts, was published in the Federal Register as a proposed rule January 23, 1979 and again March 19, 1980. At the time, Congressional opposition was raised concerning the uniform reporting effort.

As you know, hospitals were reimbursed by Medicare then based on their costs. The proposed rule was intended to facilitate accurate and appropriate reimbursement to hospitals by assessing hospitals' actual costs. However, with the development of a hospital prospective payment system, uniform hospital reporting was not pursued since hospital payment for Medicare patients was no longer tied to costs incurred by individual hospitals. Furthermore, a benefit of the prospective payment system is the relief to hospitals of burdensome record keeping and reporting which would be contradicted by imposing a detailed, uniform accounting system.

Chairman STARK. Well, you and I come from different professions. Mine is considered the second oldest in the civilized world.

There are probably 6,000 hospitals in the country and there has got to be somewhere between 10,000 and 20,000 banks. And while banking is a lot simpler, and its commodity is more uniform than in hospitals, every bank in the United States that opens the next

day balances its books the night before, and generally gets it accounting done for each month. And the Comptroller or the Federal Reserve or somebody gets a copy of this currently each month.

Then there are B-1 bombers, which I submit have more than 6,000 or 8,000 parts in each one of them. And somewhere in our great Air Force, they keep a record of every part in every bomber, how old it is and when was it last inspected, and when it was changed. And this is all a marvel to me.

But the greater marvel is that we do not do that with hospitals. We might be arguing how much we ought to spend and what is a fair rate of return for these hospitals, but we would not know exactly which hospital was getting it and which was not. And if there were outliers, I guess is the word, and some hospital for some reason was just going broke under our system, then we could push a button and sort out that 200 or 300 hospitals and look at them, and say why.

Would you join with us in suggesting that we ought to have a system of uniform accounts that are on line and current as quickly as we could? Would that be a help to you as much as it would to us?

Dr. ROPER. I would sure be glad to take a look at it, Mr. Chairman.

The point I would make, though, is we face several problems in the data that we are analyzing. One is that the accounting systems may well not be standard across the industry.

Chairman STARK. Let me stop you right there.

I suspect you are absolutely right. But it is our money that we are accounting for, and I think we have the absolute right to change that overnight.

Dr. ROPER. Sure, you are right on that point. The point I was headed towards making though, is beyond the question of what hospitals are paying out and what they are receiving as income. It is a complicated task to determine what is the Medicare portion, what is the income and outgo. Surely it can be done. I am not an accountant, but I can imagine accountants coming up with some generally accepted principles on which to base those judgments. But they will just be prudent judgments, finally, because different payors are paying different amounts to hospitals for different services.

Chairman STARK. Bill, my point is I do not care. I see nothing in our mandate which states a hospital has to make a profit on our share of its business. And that is not the issue. If we were buying medical services for the General Motors benefit plan, they do not give a hoot what percentage of Medicare patients are in that hospital, they are just buying for their employees.

And so whether or not the hospital is making a profit was not the issue as we move to the DRG system. The issue was that it is what we ought to pay for the procedure, and if the hospital goes broke, tough. And if they make a lot of money, I suppose tough on us. We ought to then lower the rate.

But it is very difficult as we get in, and then we say, well, what are we doing? And we have no way, and I am sure ProPAC has the same problem, in our own hospitals, that the hospital association has. It is a question of confidentiality. That is the only objection I

have heard, and it seems to me if that is the debate, we could get at it and find out what the problems are.

Dr. ROPER. But another concern, surely, would be that prospective payment was sold as an idea: we will pay a price, and then back off from hospitals and let them do their business and reduce the paperwork burden on hospitals. And the extensive reporting requirements that you seem to be suggesting would appear to me to be headed in the other direction, to say we want more information, not less information.

Chairman STARK. I presume we still pay about 60 percent of most hospitals' income; therefore, we would be dominant in rate setting. I think it is fair to assume that we are inextricably involved in their financial well-being. With politics being what they are, there are going to be regional pressures and all kinds of pressures on us, both the administration and the Congress.

So I think we should require that they file tax returns in some cases. And nobody seems to complain about that except that they are too much. I think the idea of paperwork burdens in an electronic information society is not relevant.

Dr. ROPER. I take your point.

The other point that I would make though, Mr. Chairman, is it is not finally a question of what is the right number to put on a page, to report to somebody. But it is the Medicare program with its taxpayer dollars buying access for Medicare beneficiaries to hospitals across America. And I think that is the appropriate measure to focus on.

Surely we can discuss and examine how to report data. But finally the question is: what happens, do people get access to quality services? And there is a lot of judgment beyond numbers.

Chairman STARK. No question. No question. And that is what I suspect supports peer review and a whole host of quality control issues.

But we are a long way from having a system that works. We are only half way or 60 percent—however far we are into the DRG system. We have been dragged, and pushed, kicking and screaming into a prospective payment system. We are still not there yet. We have all suggested, I think, the administration and this committee, and ProPAC that once we get to the DRG rates, we are going to have to do a lot of adjusting to make them fair. And I do not think that anybody thinks that is going to get done save in a couple of years. But I think we will do a better job for everybody if we have current accurate data.

It just becomes more apparent to me each year we go through this drill that we are shooting in the dark, and the problem is we do not know who we are hurting. I do not know whether you are winning or we are, and I do not think you do either. I am willing to get beat if I do not have the votes, and I am sure you are an honorable and good loser, as good a loser as I am, and you would too. But we do not know.

We come out of these forays and say who won? And you do know, and that is no fun at all. I do not know whether I should be mad or happy.

I have one more concern. In our testimony yesterday, there was some discussion of denials of payment by intermediaries. Let me tell you some of the history that I have heard.

While it has been fairly constant for skilled nursing facilities, in terms of the denial rate, home health care has gone up in several areas. As I understand it, there are two intermediaries, both operated by Aetna, who, for a long time had no denials. Then there are those operated, say by Blue Cross, who had some denials. Your office suggested that this was inappropriate; that Aetna ought to get with it and have denials like everybody else.

If that decision is made strictly on a percentage basis, a numerical basis, without regard to the quality of the denial, if you will, I think that is wrong. And if you do not have good information, as we know you do not, I do not see how you can just say I want a denial rate like everybody else has.

And, further, this comes right to the point that you and I have discussed other times; you, the administration, is pushing us to move toward capitation and HMOs.

Now, if you are going to just start this thing of saying we will not accept a denial rate of less than 30 percent because it costs too much when it gets higher, without knowing why they are being denied, and while I understand you are getting upset often by administrative law judges on appeal, that to me is an unacceptable way of reversing the regulatory thrust which is a different direction for HMOs, and say we are just going to do it on a percentage basis. You are admitting too many people into the hospital. Cut it out. Or else, I want to hear that you are not admitting enough to the hospital and why.

I am concerned. The question is, what did you say when you asked whomever you asked, to increase the rate of denials on home health care?

Dr. ROPER. We did not ask them to increase the rate of denials. We said you have strikingly lower denial rates than your colleague intermediaries; why is that the case? Either you are much more precise in how you analyze and make these payment decisions, or something else is the matter. And we are not seeking denials.

Chairman STARK. How did the intermediaries respond to that?

Dr. ROPER. I do not know. I was not personally involved in those discussions.

We are doing several things. One, moving towards 10 intermediaries that process home health claims so that coverage criteria are consistently applied across the Nation. Home health is an area that requires a great deal of judgment in deciding whether this specific claim fits within the Medicare statute. We feel that we can do that more consistently with fewer intermediaries than with the large number that we currently have across the country.

Chairman STARK. Why would we not survey it with PROs the way we do other overutilization problems?

Dr. ROPER. That potentially could be done. We are seeking to implement all the additional duties for PROs you gave us last year in COBRA and OBRA, and I urge you to hang on before you give us another one.

But my point was going to be that we are not seeking to deny claims. What we are anxious to do is get the best information avail-

able on the nature of the claim, and we are now doing that through new forms that are being used to supply that information, and then make appropriate judgments and pay these claims.

I was with Congressman Gregg in Concord last week, and some people spoke up about home health denials there. And I have heard it in other places. We are not trying to issue traffic tickets. We are trying to apply the law. That is the other point. If you will just pardon me, I will make one other point.

The Medicare statute has a rather limited home care benefit. So there are two issues. One is how are we applying that benefit and the other is the nature of the benefit. We got a GAO report a few weeks ago that says we ought to be tougher in applying the benefit. But GAO asks the right question: maybe the law ought to be changed.

Chairman STARK. Okay. Here is the problem. But your agency in its wisdom some years ago decided to start denying disability claims with absolutely no notification. It is very clear that they were just sent out as a way to save money and put the disabled person at the disadvantage. The disabled had to prove that they were disabled, which was not the way the law read.

I had a gentleman wheel himself into my district office in California who did not have any legs. He had received this notice indicating that he was no longer disabled.

But we got an immediate reaction in Congress because the checks were not mailed to our constituents, and they knew it. Suddenly that money to buy groceries or pay rent wasn't there, and they hollered out. As the cry got louder, Congress reacted. And the thing is we do not hear about home health care denials. Much of the time, the reaction to your intermediaries is not the person who just got the home health care. They have already got it, and if they are poor, they are not going to pay for it, and I guess you cannot collect from them retroactively.

What happens is the providers freeze up, and the system reacts. If it overreacts, it affects people who need it because it is too much trouble for the provider to take the risk that they will be denied. And if that is what is going on, I think we need to change the system. And I would welcome your suggestions.

Do you agree we ought to look at it if the system is not being applied fairly and we are starting to get complaints?

Dr. ROPER. Yes, and we are. Internally we have a review underway of this whole matter.

Chairman STARK. Would you be kind enough before any great changes are made in that, to review those with us?

Dr. ROPER. Be pleased to.

Chairman STARK. Thank you very much.

Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman, and than you, Dr. Roper, for being with us and for the outstanding jcb you are doing under very difficult circumstances.

I think it is important, while you are here, to send a message—at least from this Member—to the Department about why we have increasingly insisted upon what you might call micromanagement, such as taking control of the update, limiting regulations which

promise to produce savings in excess of $50 million a year, prohibiting the final regulations on capital and so forth.

I think a good example is the disproportionate share that the chairman was talking about. We thought we had taken care of disproportionate share. We had made a legislative judgment, as a Congress, that there should be an additional payment for disproportionate share.

When a hospital in California—in the Rosebud case—questioned this, you guys went to the mat with them, and even after a court ruling favorable to the hospital. Still as a department, as a government, the executive branch dragged your feet about doing something.

I think we came up with the best formula one could hope to do in a couple of weeks. I do not claim it is very good, but those who had the expertise who were in your department were unwilling to deal with the reality that we had a law on the books and we had no choice, in my opinion, but to move quickly to deal with the situation.

Now frankly, I see the same thing happening with regard to two much more recent issues: the appeals issue and the Prop A issue. There may be others that do not come immediately to my mind.

It has occurred to me, maybe because of working on tax legislation as well as health legislation, that we may need a technical corrections act each year, to clarify for the executive branch what we had in mind the year before, because I do not think that you are properly interpreting things which we did.

I would use Prop A as an example. We may not have written it very well—and if that is true, that is our fault; we can straighten that out. But I certainly did not intend, as the sponsor of that, nor do I believe that the conference that worked this over intended that Prop A be used as a means of slowing down payments.

That brings me to the question of electronically transmitted bills. What is your policy? Is it correct that you intend to—how do you intend to deal with electronically transmitted bills in contrast to the way which you have been dealing with electronically transmitted bills?

Dr. ROPER. Secretary Bowen said a couple of weeks ago, "We have that under review at the moment." He announced in December that we would, for fiscal year 1987, pay claims, on average, within about 20 days. That is consistent with the average in fiscal year 1986.

The issue that the Secretary raised recently is: what will happen this summer as some hospitals come off PIP and we would ordinarily begin paying them very rapidly? We are entertaining the possibility of a 5- to 7-day holding of electronically transmitted payments this summer in order to maintain the cycle of about 20 days, on average.

Mr. GRADISON. How much would that save?

Dr. ROPER. Just a second; $40 million.

Mr. GRADISON. Over what period of time?

Dr. ROPER. The last few months of the fiscal year 1987.

Mr. GRADISON. What would be its savings in a full fiscal year? Would it exceed or would it be higher or lower than $50 million for a full fiscal year?

Dr. ROPER. It would not change. It would not be higher than that for a full fiscal year because it is a one-time savings.

Mr. GRADISON. Has that number of $40 million been reviewed by the Congressional Budget Office, to your knowledge?

Dr. ROPER. I do not think so. It is our actuaries' number.

Mr. GRADISON. Mr. Chairman, I would hope that this committee would ask the Congressional Budget Office to review this estimate just to make sure whether, in changing this policy, the Department has, perhaps inadvertently, violated our recent rule, which has a $50 million threshold on activities of this kind.

Could we make such an inquiry, use them as an impartial umpire with regard to the estimates? Forty is so—pardon my saying this—suspiciously close to the 50 to raise the question in my mind.

Chairman STARK. The gentleman's suspicions might be well-founded, but I think we could ask CBO to do that and we could consider, that as the author of the amendment the gentleman is referring to, my initial suggestion is $25 million.

It would seem to me in this Budget Reconciliation Act we could make it $25 million and make it retroactive. [Laughter.]

Well, that is an interesting idea.

It would save CBO a little work.

Mr. GRADISON. How many claims are involved in this, Dr. Roper? What proportion of the Medicare claims will be held up to meet this new standard?

Dr. ROPER. About a third of the claims.

Mr. GRADISON. And about what proportion of the payments?

Dr. ROPER. About a third of the dollars.

Mr. GRADISON. Is it about the same amount?

Dr. ROPER. Yes.

If I could just reiterate: What we are discussing is a matter we have under review in the Department, not yet implemented. It is something that may well be necessary later this year.

I would just have to say, Congressman—and I understand how strongly you feel about this; we have talked about it a number of times—that slowing claims 5 days for some hospitals has to be weighed in the context of all the other possible savings alternatives in connection with Medicare.

Mr. GRADISON. Well, I hope you also take into account that some of these hospitals converted their billing systems to electronic means because they were advised that this would speed their collections.

One hospital in my district spent $600,000 converting so that it could speed this up. They were obviously counting on the Department continuing this payment mechanism so that they would get a sufficient payback in interest savings. Otherwise, you all would be flooded with paper.

What incentive is there to bill electronically if you are going to get paid as fast from paper?

By the way, what does it cost to process an electronic claim versus paper claim, roughly? What is the ratio?

Dr. ROPER. I do not have the figures in front of me, but it is a savings to——

Mr. GRADISON. Substantial savings to you?

Dr. ROPER. Yes.

Mr. GRADISON. I would suggest that your action may be shortsighted if the effect of it is to cause institutions to bill you with paper or, more to the point, since they are unlikely to change their system, if the effect is to slow down the increasing proportion of claims that are filed electronically, only a third, you say, are filed electronically today.

It would seem to me to be in the interest of the system to try to encourage 100 percent. Maybe that is unrealistic, but more than a third being filed this way—this does not send exactly a positive signal out that the expense to the hospital is worth incurring.

Mr. GRADISON. Thank you, Mr. Chairman.

Chairman STARK. The electronic claims were slowed down to——

Dr. ROPER. It has not happened yet.

Chairman STARK. Oh. But you are suggesting a 5-day——

Dr. ROPER. Potentially.

Chairman STARK. Where does that put them, relative to a paper claim?

Dr. ROPER. Still much faster. Average payment is twenty days. Electronic claims can be paid within two, three days. But there are many claims up in the teens or twenties in order to have an average at twenty.

Chairman STARK. So you take the electronic claim, run it through the computer and have the computer cut the checks?

Dr. ROPER. What we are discussing is holding those checks, before they go out the door, 5 to 7 days.

Chairman STARK. I guess what I am saying is a question of the paper flow: When the electronic claim comes in——

Dr. ROPER. To our intermediary, yes.

Chairman STARK [continuing]. Is it ever handled then? Is it ever transformed into a hard copy and processed by anyone, if you know?

Dr. ROPER. If it is done electronically, I believe it is all on VCRs and whatever.

Chairman STARK. Mr. Coyne?

Mr. COYNE. Thank you, Mr. Chairman.

Doctor, currently, what percentage of hospitals are operating at a deficit? Do you have any statistics that would reflect that?

Dr. ROPER. If you are asking what is their situation in fiscal year 1987—currently—we do not know that. I do not think anybody knows that.

Mr. COYNE. What is the most recent period that you have statistics for that?

Dr. ROPER. The most recent information we have is a report from the Inspector General on Medicare operating margins for fiscal year 1985—a sample of hospitals in 1985.

Mr. COYNE. What percentage was it at that point?

Dr. ROPER. I would have to check, sir. What he was reporting is the percent.

In 1984, 18.5 percent had negative margins on Medicare. We do not have full data for anything beyond 1984.

Mr. COYNE. I wonder if you would anticipate an increase in whatever figure it is today if there was to be an adjustment made to the standardized amount. Could you——

Dr. ROPER. Well, as I indicated in my testimony, we have reason to believe, although not hard evidence on all hospitals, that in fiscal year 1987—the current year—and in fiscal year 1988, under what is now being discussed, that operating margins are narrowing significantly.

I think, to answer your question, with a very low increase in the average standardized amount, the percentage of hospitals in deficit is likely to increase.

Mr. COYNE. Do you have any feeling on ProPAC's decision to calibrate the share and nonshare portions as a 4- and 8-percent split? Do you favor that or do you oppose it?

Dr. ROPER. I defer to Dr. Altman to explain in detail ProPAC's recommendations. I have heard them in detail, but I am not fully conversant with all the parts of their analysis. So I do not have a response.

Mr. COYNE. So you would not be able to make a judgment at this point of a 4- to 8-percent split versus a 50–50 split?

Dr. ROPER. Not at this time. No, sir.

Mr. COYNE. Thank you.

Chairman STARK. Mr. Moody?

Mr. MOODY. Thank you.

In my district, the home health care people are particularly concerned right now about several issues. One has been the dramatic increase in the denial rate, which jumped just enormously.

The other is that the fiscal intermediary has not been willing to share with the home health care providers the criteria on which the denials are based.

Can you comment on that?

Dr. ROPER. On which part, sir?

Mr. MOODY. Well, either or both.

Dr. ROPER. We have discussed the denials questions earlier and our desire not to have denials but to administer the law as it now stands.

Mr. MOODY. But to the outsider, the appearance was that there was, if not a quota system, then something similar to it since denials rose so precipitously in such a short time. Or else it looks as though the criteria changed dramatically.

Dr. ROPER. Well, what has changed is that in the fall of 1985, we began implementing a new form that requires more detailed information about the particular circumstances of each Medicare patient.

We believe that gives better information for making better judgments about whether somebody is covered or not covered under the Medicare program. That is not a tightening of the program; it is just better information.

Mr. MOODY. So you think more thorough information led to more denials without any change in the criteria?

Dr. ROPER. Sure, it did.

GAO has recently given us reports saying we ought to be even more careful in our application of the requirements of the law. We were criticized by GAO as being too liberal in our interpretations.

Mr. MOODY. Well, do you have these criteria that fiscal intermediaries operate under? Some of the providers in my district say they do not get them; they are not available to them.

The providers, of course, would like to see the denial rate go down; that is obvious. There is no quarrel with that. But I think they feel they could do a better job.

Dr. ROPER. If they knew what the rules were.

Mr. MOODY. Sure. If they knew the rules of the game, there would not be as many denials.

Dr. ROPER. We have underway a major education campaign across the country to do just that: to communicate to them what the rules are. Our regional offices are carrying that out right now.

Mr. MOODY. Do the fiscal intermediaries have a set of written rules before them right now?

Dr. ROPER. They have a set of general guidelines that are generally available. Those are not secrets.

Mr. MOODY. I see. Well, could someone in your office send me a copy because the fiscal intermediaries were not willing to produce anything for the providers.

But you are saying those general guidelines are all they have.

Dr. ROPER. We are giving general guidance to the intermediaries. As I said earlier, another thing we are doing is lowering the number of intermediaries so that there are fewer of them and we will have more consistent application of the advice that we give to them.

Mr. MOODY. That is not a problem in my area; we just have one. But you are saying they only have general guidelines; they do not have specific guidelines right now? Maybe that is the problem; maybe the fiscal intermediaries feel with only general guidelines, that it is pretty much up to them. Maybe, really, that is the problem.

Dr. ROPER. There is discretion that the intermediaries have.

Mr. MOODY. Is there any implied pressure on the fiscal intermediaries to pay fewer claims today than 2 years ago?

Dr. ROPER. No, sir. The number of claims being paid is going up. The amount of money we are paying, the number of people served is going up.

Mr. MOODY. Let me rephrase it.

Was there implied pressure for the denial rate to go up?

Dr. ROPER. No, sir.

Mr. MOODY. Okay. But since it did—were they operating on more specific criteria several years ago? You say they are now operating on only general criteria.

Dr. ROPER. No. The one thing that has changed is that in September of 1985 we implemented forms that provide better information on the circumstances of individual patients.

I would just say, Congressman, that I, for a number of years, ran a local health department in Alabama where we operated the largest home care agency in the state. It is something I know a fair amount about. There is a lot of judgment involved in whether a specific patient is a Medicare-covered patient or not.

What we are trying to do with this improved information is make correct judgments. Medicare does not entitle patients to all the home care they want, nor even to all they need. It is a rather limited home-care benefit.

Mr. MOODY. I understand.

On the nursing home-care portion, we had similar mystery on the part of some of the skilled nursing facility people about the criteria.

Have those changed or is that the same situation?

Dr. ROPER. They have not changed either.

Mr. MOODY. They are operating only under general guidelines plus a more thorough form to fill out; is that also the case?

Dr. ROPER. No. We have not implemented the difference in information with the skilled nursing facilities.

Mr. MOODY. I see.

Can you just take a second to explain the interaction between Medicare and Medicaid on nursing home payments? I am trying to phrase the question properly, but if the nursing home seeks payment from Medicare and is denied, then does the payment fall under Medicaid? I mean, if the patient is Medicaid eligible, would a Medicare denial jeopardize their Medicaid option at all, as far as you know?

Dr. ROPER. I am not sure I am following you; but I do not think so.

Mr. MOODY. Skilled nursing home people told me that an intermediary almost routinely denies every single Medicare application request.

They said it is almost a negligible percent of the people who are eligible. The nursing option is almost removed from Medicare in my district.

Is that consistent with your understanding?

Dr. ROPER. Well, in the skilled nursing facility the Medicare program is a very limited part; you are right. That has always been the case. About one percent of Medicare's payments go to skilled nursing facilities.

Mr. MOODY. What they were saying is it is much less likely today than it was two years ago that a Medicare nursing home——

Dr. ROPER. I think what they are probably saying is that the number of patients they want to place in skilled nursing facilities is increasing.

They are finding we are continuing to apply the criteria and the law that permit only a narrow skilled nursing facility benefit under Medicare.

Mr. MOODY. Well, I will not pursue this now. Perhaps you would be good enough to come to my district sometime as you did Mr. Gregg's.

Do you think that might be possible—I would certainly appreciate it—so we could get down to cases with the people in question.

Dr. ROPER. Surely.

Mr. MOODY. Thank you.

Thanks, Mr. Chairman.

Chairman STARK. Mr. Pickle?

Mr. PICKLE. Dr. Roper, we are glad you are here.

One of the purposes of our hearing this morning, is to try to determine the proper rate of payment for hospitals. What is a reasonable rate?

Dr. ROPER. What should it be increased by for fiscal year 1988?

Mr. PICKLE. Or reduced. What is the proper rate?

I know that in previous hearings, it has been said that the rate of increase, based on 1984 figures, was somewhere in the neighborhood of a 12-percent increase for many hospitals.

Although you apparently do not have current figures, what do you think the return would have been for 1985 or for 1986? Would you have any idea? Has it continued that high?

Dr. ROPER. Well, a number of studies have shown that in fiscal year 1984, the hospital margins on Medicare revenues were 12 to 16 percent.

Since different analyses have found roughly the same numbers, we believe that that really was the case; that is true information.

In 1985, the Inspector General has said roughly the same numbers are the case. However, in 1987 and 1988 we project a significantly different picture because in 1987, for example, inflation adjusted Medicare payments per case for hospitals will fall by 3.5 percent—actually fall—compared to 1986.

We feel that even with a 2 percent increase in the average standardized amount, which is the upper bound of the Secretary's recommendation, payments in fiscal year 1988 will fall by a similar amount compared to 1987.

In addition, as I said in my testimony, hospitals face cuts in the amount they are receiving for capital and medical education and are facing other pressures. We think we are in a significant transition period, from a time where everybody agrees they enjoyed large profits, to a time where that margin is narrowing significantly.

That information implies to us that caution is the order of the day, in making judgments about it.

Mr. PICKLE. I assume that your decision is based on contacts or studies you made of the various hospitals and the various physician groups throughout the country.

What is the source of your analysis? Do you go to the hospitals and make a study of them?

Dr. ROPER. The data I am reporting to you about 1987 and 1988 is based on how much we are paying. It is not based on visits to hospitals or audits of hospital records. We do not have that information yet for 1987 or certainly not——

Mr. PICKLE. Well, should a hospital—whether it is rural or urban or whether it is nonprofit or private—should a hospital, quote, make a profit?

Dr. ROPER. Hospitals ought to take in enough money in order to deliver the service and stay in business.

What the appropriate profit margin is, is a proven judgment. But I think they ought to have revenues in excess of expenditures; yes, sir.

Mr. PICKLE. Well, the chairman said earlier that he was not interested in whether the hospital made a profit. I presume what he meant was that the hospital should not make a profit by taking undue advantage of an illness.

It would seem to me that a hospital, regardless of whether it is rural or urban or whether it is profit or private should, as you say, at least take in more revenue than to lose. Otherwise, they are doomed. They are committed to being in a negative situation.

For that reason, I think that we ought to try to determine what is a reasonable amount of profit. That is what I am interested in.

I think our committee is concerned as much about the budgetary problems that we face as we are about reimbursement to hospitals.

We are going to be faced with specific charges in the upcoming reconciliation bill to make cuts. I think some members are trying to justify denying an increase, on that basis, even more than determing the reasonable amount.

I would like to know how you arrived at the 2-percent figure. In the statement you presented, you gave several factors. I am going to be in touch with you further.

I am just trying to determine what is a reasonable rate of payment. I do not think we should just set a goal that the rate should be less just because we have targets for budget reduction unless we can justify them.

Dr. ROPER. Let me just clarify a point I made and then respond to your question, Congressman.

It is not our goal to keep in business every hospital in the country nor are we trying to put hospitals out of business. What we are trying to do in Medicare is to pay an amount that will buy access for Medicare beneficiaries to quality health care services all across America.

Now to the point of how we got to the range of 1.5 to 2 percent, which is the Secretary's recommendation of the day. We looked at the information that has come available since the President's budget was published in January, in which we recommended 1.5 percent, and the evidence that has come forward is the formerly increasing case mix index for hospitals nationwide has plateaued.

The case mix index or creep or whatever you choose to call it is no longer going up. That is a change from the past. We do not know whether it is a temporary or a permanent phenomenon, but it is definitely a change and has, therefore, limited one of the ways in which hospitals got additional money beyond the actual increase in the average standardized amount.

The other thing that we have taken into consideration is the information that I have given you about a real decrease in fiscal year 1987 compared with 1986 of inflation-adjusted Medicare payments per case and what we see as a likely further reduction in that amount for fiscal year 1988 that tell us that we are in a transition. Despite all the reports that you have heard of hospital profits, large-scale in 1984 and carrying over into 1985, we are in a different world right now and that causes us to say that we need to continue the course of modest increases well below the increase in hospital input costs—modest increases but more than was in the President's budget of 1.5 percent, 1.5 to 2 percent is the Secretary's recommendation.

Chairman STARK. Would the gentleman yield just for a moment?

Mr. PICKLE. Yes.

Chairman STARK. On a personal point there.

I think you said I indicated that I did not care about hospital profits, and that is not correct. I do care.

The DRG system does not take profits into account. The idea behind the DRG system, which I did not invent, is that we just ought to pay a certain amount, and if hospitals make a profit, fine, and if they do not, fine.

I believe, Dr. Roper, that is the case.

I merely was pointing out that that is what the system calls for, Mr. Pickle. It is not my philosophy that hospitals should not make a profit, and I want to make that point for the record.

Mr. PICKLE. Well, I am glad to have your comments. I had this strong feeling that you were as interested in the budget figures as you were in whether hospitals made a profit or not.

I am not trying to say that hospitals ought to make a big profit. At the same time, I do not think they ought to go in the hole because they cannot stay in the business if they just try to break even exactly. But that is besides the point.

Let me say one more thing to you, Dr. Roper.

You said that you are recommending 2 percent now.

Dr. ROPER. 1.5 to 2 percent.

Mr. PICKLE. But if figures change between now and the beginning of a new fiscal year, you might make further recommendations.

Dr. ROPER. Yes, sir.

Mr. PICKLE. New figures could change your recommendation up or down, depending on how the figures will develop. The problem is we are so budget-conscious that our Budget Committee is probably going to make its recommendation next week, we are told.

If that happens, then we will probably already have a charge from that committee to make a certain level of savings. The pressure is going to be very strong for us to make savings in this area as in a lot of other areas. How in the world we can do it is going to be our problem.

We cannot wait until the fall for you to make a different estimate. Time has us in a vise. We do not know how to proceed, other than I will make the observation, again—we must try to find the truly reasonable payment level through DRG.

We set up DRG because we wanted to cut back on hospital costs. We wanted them to stay even, to try to keep hospitals strong. They have done it.

Now the question is: Are we doing too much? Is it too heavy an increase or should we maintain a level at the present rate or the rate you are suggesting?

So I would be interested in having any information you can give me regarding why you are recommending this slight increase.

Thank you.

Dr. ROPER. Thank you, sir.

[The following was subsequently received:]

We are recommending a modest increase because Medicare program data indicate that hospitals generally have been doing well under the prospective payment system, with average operating margins of 12 to 16 percent in FY 1984. The Inspector General found similar margins persisting into FY 1985 for a statistically representative sample of hospitals. The high operating margins observed in the first two years of PPS appear to be due, in part, to rates that were initially overstated because they were based on unaudited data. We have therefore recommended in previous years a modest increase in the rates to compensate for this and the more efficient hospital management of health care resources. We believe that such an approach is also the appropriate policy for fiscal year 1988. In this way, the Medicare program would continue to benefit from the changes in hospital behavior that have resulted from the prospective payment system, while at the same time avoiding financial dislocation in hospitals.

Chairman STARK. Mr. Gregg?

Mr. GREGG. Thank you. Many of the issues I was interested in have been covered rather thoroughly and, I think, very well.

I would just say as an aside that you have received a bit of a boxing around the ears today on the availability of numbers from your agency, it seems. I would say that maybe you have taught this committee something because we, on this committee, also find it hard, from within the committee, to find numbers from some of our joint staff people. So your policies have maybe been adopted by our own committee. I wish Mr. Daub were here because I think he feels the same way.

I was interested in a side issue, which is the question of whether or not or how you think we should approach the physician's reimbursement over the next couple of years.

Dr. ROPER. You mean, in general, how should we reform physician payment under the Medicare program?

Mr. GREGG. Right. How are we going to address this problem, which seems to be one of the key pressure points in the structure.

Dr. ROPER. I think the prudent course to go in physician payment and part B reform in general would be to use the tools we have at hand to make sure we are not overpaying for selected procedures—the so-called inherent reasonableness authority which is now limited in some respects—to push ahead, to deal with overpayments in some areas.

But, as a second point, all need to move towards a payment system that is more fully based on what we until recently were calling capitation and are now calling the private health plan option for Medicare, in which Medicare beneficiaries enroll in private plans and leave to them the arrangements of how much to pay doctors and how much to pay hospitals.

There are other ways to go. We have underway a study of relative value scales on which fee schedules could be based. We will carry out that study expeditiously. But I am not persuaded that an administered price system for doctors is any better than an administered price system for hospitals, which we just spent the last hour and a half talking about.

Mr. GREGG. So where do you think you are going to come down?

Dr. ROPER. Continued restraint in dealing with particular specialty areas and types of procedures while moving the system more towards a basis of capitation.

An example of dealing with particular specialty areas is our proposal in the budget to begin paying hospital-based radiologists, anesthesiologists, and pathologists on a DRG basis. We are going to be coming forward to you shortly on that.

Mr. GREGG. Thank you.

Chairman STARK. I just wanted to interrupt.

That is the administration's recommendation, is it not?

Dr. ROPER. Which?

Chairman STARK. On paying the raps under——

Dr. ROPER. Sure.

Chairman STARK. I just wanted to make that point—without prejudice.

Mr. Donnelly?

Mr. DONNELLY. I have no questions.

Chairman STARK. Mr. Levin?

Mr. LEVIN. Thank you.

Dr. Roper, I have been trying, from your testimony, to piece it together with Dr. Altman's testimony to come. You seem to be coming to a closer conclusion.

But do you have any comments on the elements within ProPAC's table on page 3? Have you seen Dr. Altman's testimony?

Dr. ROPER. No, I have not seen his testimony. But I have gone over how they compute their 2.3 percent recommendation.

Mr. LEVIN. Would you comment on that because there seemed to me to be some substantial differences of the conclusion is fairly close. Maybe I am wrong. That is going to be critical as we try to reach a conclusion. The bottom line is not going to be the only important factor, right? We are going to have to dissect the components.

Dr. ROPER. Well, I defer to Dr. Altman to explain their recommendation. But I understand the difficulty you face, the comparison or crosswalk, if you will, from their numbers to our numbers.

I had a couple of hours' explanation by the Executive Director of ProPAC of their recommendations, and I have to tell you it is complicated.

The major differences between ProPAC's recommendations and ours, though, are relatively few. The bottom line number—their recommendation is 2.3 percent. The Secretary's is between 1.5 and 2 percent.

The second major difference: They recommend a difference in the standardized amount for urban hospitals and rural hospitals. At this time, we do not.

Third, they recommend a change in payment levels based on the earlier overpayments in the first years of PPS. We are not currently recommending such a reworking of the payment levels.

Those seem to me to be the basic differences.

Mr. LEVIN. But in view of the latter, then there are some other important differences in your assumptions; right? It seems to me, in view of the fact you do not take into account the past to arrive at your 2 percent——

Dr. ROPER. Oh, but we do, sir. We just do it in a different fashion. Rather than a fundamental reworking of the numbers, we have had very modest, very small increases in the last couple of years. We believe that, along with another modest increase for this year, takes account of the overstated payments in 1984 and 1985.

Mr. LEVIN. Are your case mix assumptions the factor that you ascribed to that more or less the sign?

Dr. ROPER. Again, I would defer to ProPAC. But I believe our number is—as an assumption—a zero case mix increase and their numbers are net zero. So it is basically the same.

Mr. LEVIN. They have a factor estimated total change in case mix index for fiscal year 1987 a negative 1.3.

Maybe this is not the time you want to do this. But I think you are going to need to provide us an analysis at some point because, again, to simply say you have altered the range to 2 percent and it is close to 2.3 percent, when it comes down to the hard decision as to where we go on this, we are going to need to understand your views on the components.

Okay?

Dr. ROPER. I understand your question, and we are currently learning about ProPAC's recommendations. We will be glad to discuss those with you.

Mr. LEVIN. Just one last question.

Have you read the hospital association testimony? Have you seen it?

Dr. ROPER. No, sir, I have not.

Mr. LEVIN. All right. Maybe at some point you could comment on it. If you could look it over and give us the benefit of your analysis of it.

Dr. ROPER. Be glad to.

Mr. LEVIN. Thank you very much, Mr. Chairman.

[The following was subsequently received:]

SUMMARY OF THE AMERICAN HOSPITAL ASSOCIATION'S TESTIMONY

On April 1, 1987, the American Hospital Association (AHA) testified before the Ways and Means Committee, Subcommittee on Health on the fiscal year 1988 recommendations of the Prospective Payment Assessment Commission (ProPAC) and related reconciliation issues. The following major issues concerning hospitals, beneficiaries and the Medicare program was discussed:

UPDATE FACTOR AND REBASING

AHA believes that the FY 1988 update should equal the full increase in the market basket, explaining that an increase equal to the market basket would require hospitals to further improve productivity in light of changing patient mix and intensity of treatment. Anything less would place hospitals in a difficult financial position.

AHA is strongly opposed to rebasing as a means of adjusting the PPS payment levels, because it is inconsistent with the original design of PPS and because they believe adequate data for rebasing does not exist.

The Administration believes that modest increases in previous years along with the Secretary's recommendation for FY 1988 will account for previous rates which were set too high because they were based on unaudited data. We also believe the update factor recommended by the Secretary is more appropriate than the ProPAC recommendation.

Rather than make precipitous cuts in hospitals' rates based on margin data from the first or second years of PPS, we believe we should continue to pursue a policy of steady, gradual reductions.

PPS REFINEMENTS

AHA also addressed ProPAC's recommended adjustments separate from the update factor to refine the methods used to determine hospitals payments.

Rural Hospital Studies—AHA supports ProPAC's recommendations to complete the studies on the feasibility of eliminating the urban and rural differential. AHA believes that the difference in payment between urban and rural hospitals should be narrowed to reflect changing patterns of utilization in rural hospitals.

They also believe that a better measure of case-mix should be developed.

A report mandated by Congress on rural hospital issues is expected to be sent to Congress early this fall. Preliminary findings suggest that with the implementation of provisions contained in OBRA 1986, the disparity between urban and rural hospital is largely eliminated. Currently there is no satisfactory method for measuring changes in the mix of patients within DRGs. The Department is, however, engaged in extensive research in and evaluation of this area, and we expect to be able to make additional refinements to the system in the future.

Wage Index—AHA agrees with ProPAC's recommendation to refine the area wage index to reflect more recent wage data, but differs as to how that refinement should be accomplished. While ProPAC recommends a distinction between urbanized and non-urbanized portions of metropolitan statistical areas (MSAs) and rural counties, AHA recommends that area wage indices be adjusted through an exceptions process.

The wage index currently in effect is specified in statute. This index reflects the most current and accurate data available. The Department continues to evaluate alternative approaches and options in defining labor market areas. Because the wage index affects every hospital's payment under PPS, we believe it vital to carefully assess the impact of alternative definitions and measures.

Sole Community Hospitals—AHA also concurs with ProPAC's recommendation to expand the eligibility for sole community hospital status which would permit a volume adjustment to all isolated rural hospitals. AHA has also developed a specific approach to recognize the difficult operating environment of hospitals.

The Administration is evaluating ProPAC recommendations.

Outliers—AHA concurs with the ProPAC recommendation that current methods of defining and paying for outliers be further evaluated, believing that they are particularly inadequate for small hospitals.

The Administration continuing to study the impact of the outlier policy on all hospitals.

PAYMENT RELATED ISSUES

AHA also presented testimony on a number of changes proposed by the Administration, not addressed by ProPAC. Although not technically a part of PPS, AHA believes the elements described below sufficiently impact the ability of hospitals to serve both Medicare patients and their communities, as to warrant comment.

Indirect Medical Education—AHA would make no change in the indirect medical education payment factor at this time. They believe that changes in the formula would require teaching hospitals to make substantive changes in the services they offer.

The Administration believes there is no evidence to support doubling the indirect medical education payment adjustment.

Direct Medical Education—AHA opposes any restrictions on payment for direct medical education, particularly the provisions of the Administration's proposal to eliminate the costs of educating nurses and other allied health professionals. AHA would encourage Congress to delay its decision until results are available on the study of Medicare-approved educational activities.

Under original legislative intent, these educational activities were ultimately to be supported by the community. We believe, therefore, that Medicare should no longer support these activities.

Elimination of PIP for Disproportionate Share Hospitals—AHA opposes the Administration's proposed elimination of periodic interim payments (PIP) for disproportionate share hospitals. They believe that the increased costs of financing working capital would be a significant burden for these facilities.

The evidence available shows that disproportionate share hospitals are faring as well as other hospitals.

Transitional Care—AHA proposes that Title XVIII be amended to permit hospitals to provide all levels of care: acute, sub-acute, and post-acute care. AHA believes this would improve the quality and continuity of care at minimal cost to the Medicare program.

All available evidence indicates that Medicare beneficiaries are able to obtain necessary care at the appropriate levels and in appropriate settings.

CAPITAL PAYMENTS

AHA believes that cost-based payment for capital expenditures should be continued. AHA also maintains that there is no evidence, as the Administration and ProPAC believe, that a continuation of cost-based payment will result in inefficient use of resources. AHA recommends that any action to incorporate capital into PPS be delayed until at least October 1, 1989, to provide additional time for development, evaluation, and refinement of a method for paying capital-related costs.

We believe that the method of capital payment developed by HCFA with input from the ProPAC is a very reasonable and effective method of incorporating capital costs into the prospective payment system as Congress has directed. Incorporating capital payments into the prospective payment system will provide positive incentives for the efficient use of capital.

DRG REFINEMENT

AHA supports ProPAC's recommendations to create several new DRG's to accommodate the development of new technologies, and to modify the way in which the DRG system addresses patient age and other factors.

The Administration will be publishing a regulation soon that will reflect changes in the DRG system that are very similar to ProPAC's recommendation.

BENEFICIARY PROVISIONS

AHA supports ProPAC's recommendations calling for changes in the level of inpatient hospital cost-sharing that would return the proportion of hospital payments borne by Medicare beneficiaries to its pre-PPS level. It also supports the further evaluation of PRO quality of care review activities.

The Administration believes that our catastrophic health proposal would appropriately restructure the benefit package and modify beneficiary cost-sharing provisions. Further, we believe that we are adequately assessing PRO performance in the area of quality of care review.

Chairman STARK. Any members have further——

Mr. MOODY. Just a brief question.

Dr. Roper, back on the nursing homes for a second. One of the things they mentioned to me was that if they are off waiver for the reasons I am sure you understand, and if a patient comes in who is eligible for title 19, then if the request for Medicare coverage for the skilled nursing facility is denied, they can bill title 19.

However, I am told that if the patient is not eligible for title 19 due to assets or age, and they apply for Medicare coverage for a skilled nursing facility and are denied, then the nursing facility is precluded from billing the family.

What they can do under title 19, they cannot do with the family. So what that means is they are systematically much more cautious in applying for Medicare in cases where people are not eligible for title 19 because they cannot bill the family. The institution has to eat the cost.

This distorts the decisionmaking at the skilled nursing facility level systematically away from people who are not eligible under title 19. If the nursing homes are off waiver, they do not even want to try—particularly now with so many denials coming down—to put patients on Medicare, even though in some cases it probably would be okay.

In other words, it disadvantages the nontitle 19 eligible family because of the extra risk the institution is facing in that instance.

Can you comment on that? Is that a law or is that a regulation that they cannot bill the family?

Dr. ROPER. Congressman, I pledge to you to get you an answer to your question. But I cannot do that right now.

Mr. MOODY. Thank you very much.

[The following was subsequently received:]

In most instances, skilled nursing facilities (SNFs) have had sufficient experience with the Medicare program to determine, prior to admission, whether a patient's care will be covered under Medicare. If, however, care is subsequently denied, the SNF will still be paid if it is presumed to have acted in good faith in believing such care would be covered. This presumption is made for SNFs whose denial rate is under five percent. Beneficiaries are also not held liable for services they could not have known would not be covered by Medicare. Only in the instance where services were provided, and the SNF and/or the beneficiary knew these services would not be covered by Medicare would the NSF or the beneficiary be liable for payment. In these instances, the families of beneficiaries could not be held liable for payment.

Nevertheless, we do not believe the inability to hold the family responsible has generally been a barrier to SNFs admitting Medicare patients.

The Administration supports prior authorization for Medicare SNF care. We believe that this mechanism will eliminate both the need for beneficiary wavier of liability and attendant access problems.

Chairman STARK. Dr. Roper, thank you very much and we look forward to working with you over the next months as we try to come up with a reconciliation package that will be a fair and equitable compromise. We will appreciate your continued cooperation toward that end.

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION [ProPAC], ACCOMPANIED BY DONALD A. YOUNG, M.D., EXECUTIVE DIRECTOR

Mr. ALTMAN. Thank you, Mr. Chairman.

Before I begin with my formal remarks, I would like to comment specifically on the two issues that you and Mr. Gradison raised, concerning one bringing about more common data elements between the various groups that recommend to you.

I very much appreciate the position you are in, and I find myself in the same position in terms of trying to understand what we should recommend to you. Because I do see us as sort of an intermediate body between the various groups and yourselves.

And I can say this: In the past year I have felt much more reassured by the willingness of HCFA and the Hospital Association to develop a greater discussion between us. And while Mr. Levin had some problems, that I can appreciate, understanding the difference between our recommendations and the administration's, I think we are much closer today to a common format.

That doesn't mean that we agree, and I think it would be unrealistic to expect us always to agree. But at least I have a feeling that in the future you could at least be able to see a common table that each group uses to make recommendations to you before you have to make the final decision. That would be my first comment.

The second one, with respect to quicker information. We have a recommendation to you and to the administration of introducing what we call a sample speed audit. The idea that we are sitting here in——

Chairman STARK. A what?

Mr. ALTMAN. A speed audit, where the system could provide us all with much quicker information to make our assessment. I mean, we had this hearing a month ago before you, Mr. Chairman, and the idea that we were sitting here in 1987 talking about 1988, just figuring out what happened in 1984, leads us to feel a little uncomfortable. That is why I pushed, and the Commission has made a recommendation to you and the administration, about developing faster information.

Chairman STARK. Would the gentleman mind if I interrupted at that point?

Mr. ALTMAN. Sure.

Chairman STARK. Isn't there a difference between reporting and an audit? An audit, as I think of it, is a review and how the numbers ought to be arranged and when they ought to be sent and what they ought to include.

Mr. ALTMAN. Yes.

Chairman STARK. Would you support the idea that first we ought to get——

Mr. ALTMAN. Yes. My use of the word "audit" was not in the accounting sense. And I agree with you wholeheartedly, and our recommendation does not refer to a technical accounting audit. It refers to a quick shot, if you will, of information that has become available from the hospital.

Chairman STARK. Thanks very much.

Mr. ALTMAN. I would like now to proceed to my more formal remarks. First, let me introduce Don Young, who is the executive director of ProPAC's staff. I would say for the record that thanks to him and his staff we have met for the third year our deadline for issuing our report. It is April 1st and you have it, I think, before you. I have to give all the credit to the staff because my record was notorious when I was in Washington; I missed deadlines at least by a day every time. So I would like to thank the staff formally.

The Commission has tried to present you with our best recommendations. We did suffer this year as in the past in that we did not know much of what the administration would be recommending. So we, too, will be bringing to you when we get what they are formally recommending our assessment of where we agree and where we disagree.

I will submit my complete—if it is all right with you, Mr. Chairman the complete testimony for the record.

Chairman STARK. Without objection.

Mr. ALTMAN. Let me summarize, now. For fiscal year 1988, the Commission recommends an increase in the level of prices of 2.2 percent for urban hospitals and 3 percent for rural hospitals. We have gone through the following set of calculations to arrive at these figures. You have before you a table which summarizes them. It is called Estimated Increase in PPS Prices for Fiscal Year 1988 Under Commission Recommendations.

First, let me get at the issue which is the most controversial, and that is a reduction in the standardized amount to reflect what we consider to be an overstatement in the first year cost estimates.

After calculating payments that had been given to the hospitals in previous years and reductions from that, we come out with an estimate of 5.4 percent which we believe that the program should be removed from hospital rates by reducing future standardized amounts. And we further recommended that this 5.4 percent be reduced over 3 years, and that it be effected differentially between rural and urban. We recommended a 1.9 percent reduction for urban hospitals and a 1.1 percent reduction for rural hospitals. And that was our first step which appear in that first table called ProPAC's Treatment of First-Year PPS Cost Differentials. The average is 1.8 percent per year for 3 years split between urban and rural hospitals.

We next looked at the issue of the market basket, and we used the same DRI estimate as HCFA, and the current estimate is that inflation in the hospital market basket will be 4.9.

We then looked at the issue of scientific and technological advances based on the law and made a guesstimate—I don't want to

give it any more credence than that hospitals should receive a 0.5 percent increase for this factor.

I want to emphasize that this is not a perfectly accurate assessment of what they will spend or should spend, because the information just is not of that level of precision. However, we have more information today than we have ever had, and that is why we have phased it back from the 1.5 percent which we had in earlier years. So that while it is not perfect, I believe it is the best that is available.

We also, as was discussed previously by Mr. Pickle and Mr. Levin, looked at case mix and recommended that there be a 1.3 percent increase for real case mix, which would be balanced by future reductions to arrive at that overall zero case-mix increase.

We also focused on the issue of hospital productivity. This, again, is a very complicated and controversial area. We believe that the law anticipated that productivity advances by the industry should be shared between the industry and the program and beneficiaries.

Again, we are dealing with an area where there is no precision. Unfortunately, my colleagues in the research community have not provided us with a good estimate of what hospital productivity is or, even more important, what it should be.

So we have been forced to rely on a variety of simplifying assumptions and we have also looked at other sectors of our economy. We have come up with a number which I feel reasonably comfortable with, which is that productivity goals for the industry should be in the 2 percent range per year, and that this should be shared equally between the program and the hospitals. And therefore, we have recommended productivity adjustment of 1 percent.

When you add and subtract the appropriate figures, you ultimately come down to a recommended increase of, first, 4.1 percent, and then adjusting for that 1.8 in reduction in the standardized amount, you arrive at our final estimate that the standardized amount for 1988 be increased by 2.3 percent on average. This turns into a 2.2 percent increase for urban hospitals and a 3 percent increase for rural hospitals.

I want to focus a bit, again, on the issue of whether the standardized amount should be adjusted. Neither the administration nor the hospital industry have made such an adjustment. I don't know how the administration could have come to 2 percent without implicitly making such an adjustment, regardless of what they call it, because the numbers just don't take you from 4.9 to 2 without doing something someplace. But I would be interested in seeing their calculations.

The hospitals will argue that recalculation is not an appropriate adjustment, that that is not what the system was set up to do. I don't agree. I think it is appropriate for you, us, everybody, to look at what the history of the program is in relationship to costs and revenues. That does not mean that we should blindly use those numbers in calculating the rate.

We oppose rebasing, which I define as a mechanical, arithmetical reduction based on these numbers. Nevertheless, we knew when we started this program that we were basing it on very imperfect information. And when you are dealing with a subject as complicated as this, it is not inappropriate over the first few years, as the chair-

man indicated, to make adjustments to get the system on an even course. I don't think this should be done every year. I do believe you should look at it, but I don't believe we should just go about doing it every year. But I think it is very important as we bring the standardized amount in line for future years that we take account of it, and that is why we recommended the reduction of 1.8 percent a year for 3 years.

Again, this is not returning to cost-based reimbursement. Nothing could be further from the fact. The fact is that you should look at costs. IBM looks at costs when it computes the price of computers. So does DEC, and so do the Japanese. And when costs go down, regardless of what IBM wants, they are forced to lower their price.

Unfortunately, in this calculation we don't have any Japanese equivalent to force the price down to where the market should be, and therefore the responsibility ultimately falls on you or the administration. So I believe very strongly that these kinds of changes should be made, but not on a mechanical basis.

Let me now turn to other issues, which are also summarized in my testimony, which deal with things other than the update factor. As I indicated, we strongly support the availability of early information for the reasons I have indicated.

You need to focus on excluded hospitals. It is a part of the law. We have looked at excluded hospitals and have tried to give you our best recommendation. To some extent, they are under the same system as all other hospitals in the sense that they too have to buy goods and services from the same economic system. But they are also under a different set of incentives.

They do not benefit from coding increases or coding decreases. They should be under the same pressure for productivity increases. And therefore, when we finally looked at the pros and cons and the ups and downs we recommended that excluded hospitals be given an increase which is separate from the update factor for regular hospitals but is generally in line with inflation. In our detailed report, we describe our recommendation for excluded hospitals, which suggests an increase of 4.4 percent.

As you know well, we have been looking at the issue of capital. We continue to believe that it is appropriate and important that capital be included in the DRG payment. We have tried to make a series of recommendations that take account of problems. We have recommended that you separate the fixed and movable capital, and that you phase in both of them under different time frames appropriate to each.

We recommended that there be some policy for appeals under a new capital system, because some hospitals will be hurt disproportionately, particularly those that are about to bring on line very major capital investments, and you want to look at them. But by and large, if you are going to have a prospective system for the operating budget, to continue to pay capital on a cost basis creates an artificial line between two types of resources. When you do that, over time, you distort behavior. We have seen it time and again. You will be treating labor different than capital. And if you treat capital more liberally, it will be an incentive to increasingly capitalize. If you treat them less, you will do the opposite. And I would

hope that over time the Congress would deal with this issue and you might follow our recommendations.

In the area of developing hospital labor markets we have been trying to titrate the system so that hospitals receive payments which are closer in line with the wages they have to pay. And we have recommended to you and the administration that they not only break these hospital labor markets into urban and rural, but that they look within the urban area at inner city or core urban as well as suburban. There are some hospitals that are being hurt by this averaging between them both.

Likewise, in rural areas, we believe that there is a difference between the very rural communities in our country and those which are close to urban areas, and we recommend that there be a differentiation created between them.

As was discussed by many of you, we are concerned about rural hospitals. We do believe that the original payments under PPS inadvertently penalized rural hospitals in a number of ways, and we have made a series of recommendations about how to deal with this. And again, these recommendations are in more detail in our report and I would be glad to discuss them with you if you are interested.

We continue to be concerned about beneficiary payments and whether we are treating beneficiaries fairly. We recommended to you last year that beneficiary cost-sharing had gone up disproportionately and, in our view, in excess of what was appropriate. You made a change in legislation which essentially brought the deductible in line to what we believe is correct. We are now making recommendations about how to treat the coinsurance rates. Not to take the beneficiaries off the financial hook, but to bring their payments in line with what they were before the DRG system.

As we read the law, there was no attempt in the legislative language to require beneficiaries to pay a greater proportion of the Medicare program, but that is what they are paying, based on the way the system worked out. Therefore, we have made some recommendations on how to improve it.

Finally, there is a whole series of recommendations on improving the DRG system. Our mandate from you was to make recommendations on changes both with respect to new types of technology to make the system work fairer, and throughout our report you will see a series of recommendations. Again, I would be more than pleased to discuss each of them or any of them you see fit.

But let me stop at this point and again thank you for your patience with us. We really appreciate the help that we have received from you and from your staff, and I thank you for your kind words. I look forward to working with you for the next three years. Thank you very much.

[The prepared statement follows:]

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN,
PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

I am pleased to appear before the Subcommittee today to discuss ProPAC's 1987 recommendations on updating and modifying the Medicare PPS system. I am accompanied by the Commission's Executive Director, Donald A. Young, M.D.

Our third annual April Report, with its recommendations to the Secretary of the Department of Health and Human Services, was published today. Members of the Subcommittee have received copies, and a limited number of copies are available for the public here today. Additional copies of the report and copies of the Technical Appendixes to the report are available from ProPAC's office. The report contains 28 recommendations which we believe are important to assure that PPS payment rates and the DRGs remain appropriate and up-to-date. The recommendations reflect the collective judgment of ProPAC's 17 Commissioners on issues of substantial importance to beneficiaries, hospitals, and the Medicare program.

I will not describe all of our recommendations in detail today, but rather focus on the issue the Subcommittee is most interested in -- updating the Medicare hospital payment amounts for fiscal year 1988.

I want to note at the outset that the market basket and case mix components of the update factor may change when new data become available later in the year. At our June Commission meeting we will make any necessary modifications to the recommendation published today. These modifications will be publicized as part of our comments on the Secretary's notice of proposed rule-making.

I would like to submit for the hearing record a copy of the executive summary of the report, which lists each of the Commission's recommendations. After discussion of our PPS update recommendations, I will mention briefly several other areas of particular significance where we have offered recommendations, including updating payments for hospitals and units excluded from PPS.

Updating the PPS Payment--Overview

For fiscal year 1988 payments, the Commission recommends an increase in the level of prices of 2.2% for urban hospitals and 3.0% for rural hospitals. These update factors are derived by combining several components.

The first component is a 5.4% average reduction in the standardized amounts, to be phased in over the next three years. This reflects recently discovered differences between projected and actual costs during the first year of PPS. The result is a decrease of 1.9% for urban hospitals and 1.1% for rural hospitals for fiscal year 1988.

The other components are: increases of 4.9% for inflation in the hospital market basket, 0.5% for scientific and technological advances, and 1.3% for real case-mix change; and decreases of 1.0% for improvements in hospital productivity, 0.3% for shifts in the site of service, and 1.3% for expected changes in the case-mix index. These components are summarized in the following table:

Estimated Increase in PPS Prices for Fiscal Year 1988 Under Commission Recommendations

Adjustment to level of standardized amounts*	
Urban	-1.9
Rural	-1.1
Average adjustment to standardized amounts	**-1.8**
Fiscal Year 1988 Update Factor	
Fiscal year 1988 market basket forecast	4.9
Correction for fiscal year 1987 forecast error	0.0
Components of discretionary adjustment factor	
Scientific and technological advancement	0.5
Productivity	-1.0
Site substitution	-0.3
Real case-mix change in fiscal year 1987	
DRG case-mix index	0.8
Within DRG patient complexity	0.5
Total discretionary adjustment factor	0.5
Estimated total change in case-mix index for fiscal year 1987 (DRG weights adjusted after recalibration)	-1.3
Subtotal: Update and case-mix adjustment	**4.1**
Total change in PPS prices	
Urban	2.2
Rural	3.0
Average total change in PPS prices	**2.3**

* A total adjustment averaging 5.4 percent to be made in three equal increments through fiscal year 1990.

Let me now address each of the update factor components in some detail, and describe the reasoning behind our recommendations.

Adjustment to the Level of Standardized Amounts

As I have indicated, our recommendation calls for the update factor to first involve an adjustment to lower the level of the PPS standardized amounts an average of 5.4%. The urban standardized amount would be reduced by 5.7% and the rural amount by 3.3%. We believe that the adjustment should be phased in over a three year period, in three equal increments averaging 1.8%, beginning in fiscal year 1988.

In past reports, the Commission recommended that when actual cost data reflecting hospital experience under PPS became available, the standardized amounts should be recalculated. This does not mean a return to a cost based system, but rather the use of more accurate information to establish the base for future price levels. The Commission rejects the idea that the standardized amounts should be rebased each year to reflect the actual cost of operating the program in previous years. We do believe, however, that it is important to know what these prior costs were and to use this information in calculating future rates.

Actual cost data are now available, and ProPAC staff has used this first-year PPS Medicare cost report data to recalculate the standardized amounts. In this analysis, costs per case from the first-year PPS cost reports were substituted for the 1981 costs per case, which were used originally in calculating the standardized amounts. The results show that the recalculated fiscal year 1987 standardized amounts, on average, are 12.3% lower than the current standardized amounts. The recalculated national urban standardized amount is 13.0%, or about $385 lower than the current amount. The recalculated national rural standardized amount is 7.6%, or about $185 lower. The 12.3% figure weights the two amounts -- urban and rural -- by the proportion of PPS payments they reflect.

It was expected that there would be differences between projected and actual first year costs under PPS. The magnitude of the difference, however, was much larger than expected. The original standardized amounts were projections of what hospital costs would have been if the pre-PPS system had been in effect. They were based on unaudited 1981 cost figures and an estimate of inflation in the goods and services used by hospitals. The actual cost figures reflect a full year of hospital experience under PPS. During this period, hospitals had new incentives to reduce costs including shifting out of the hospital services that had been included in the original cost base.

A great deal of judgment is required in deciding how to use this information to set the appropriate level of PPS prices. In its deliberations, the Commission reviewed a variety of approaches, and considered reductions ranging from 3.4% - 8.0%.

The table which follows summarized the judgments made by the Commission in deciding to recommend a 5.4% average cumulative adjustment.

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ProPAC Treatment of First-Year PPS Cost Differential

Total cost differential	12.0%[a]
"Non-shareable" portion[b]	4.0
"Shareable" portion[c]	8.0
Medicare Proportion of Total Difference:	
"Non-shareable" portion of cost differential	4.0%
Medicare's half of "shareable" cost reductions	4.0
Subtotal appropriate average reduction	**8.0**
Reductions accounted for in previous updates[d]	-2.6
Total recommended average adjustment[e]	**5.4**
Urban adjustment	5.7
Rural adjustment	3.3

a For purposes of these calculations, the estimated cost difference of 12.3% was rounded to 12.0%.
b The portion of the differential attributed to shifts in site of care, errors in projecting costs, changes in hospital accounting practices, and auditing of cost reports.
c Cost reductions attributed to increased hospital efficiency.
d Estimated difference between actual updates for fiscal years 1985 through 1987 and what updates would have been if applied to a lower base.
e Reduction to be phased in equally over three years.

The Commission began with a rounded estimated of 12.0% of the average cost differential. The Commission's urban and rural recommended reductions are in the same proportions as the rural and urban standardized amount differentials (7.6% and 13.0%).

The Commission then considered several factors to determine the ultimate recommendation. First was the extent to which hospitals should share in the gains from PPS. In previous recommendations, ProPAC has argued that efficiency gains should be shared equally between the hospital industry and the Medicare program and its beneficiaries. It is primarily because of the importance we place on sharing gains with hospitals that the Commission opposes a strict rebasing of the standardized amounts -- that is, adjusting the standardized amounts for the entire 12 percent differential. We believe this would be inconsistent with the basic incentives of PPS.

However, we do not believe that the entire cost difference should be shared. In ProPAC's judgment, 4.0% of the 12.0% cost differential should not be shared with the hospital industry. This portion takes into account our estimate of the amount of costs included in the original figures that were shifted to other sites of care and paid for by either the Medicare program or the beneficiary. In addition to efficiency gains and site substitution, part of the 12% difference may have arisen from errors in projecting costs and changes in hospital accounting practices. Small auditing effects might also be reflected in the 12 percent cost differential.

The Commission's recommendation apportions the remaining 8% of the cost differential equally between Medicare and the hospital industry. The total reduction we consider appropriate is therefore 8%: 4% that is not to be shared with the industry, and 4% that is Medicare's half of the efficiency gains.

We also considered the extent to which PPS payments have already been reduced as a result of hospitals' early PPS experience. That is, although first-year cost report data were not available until recently, decision-makers were generally aware that the hospital industry was responding to PPS incentives, and that hospitals were doing well financially. ProPAC believes that this general assessment was reflected in the relatively low update factors allowed in fiscal years 1986 and 1987.

The extent to which prior year update amounts have already been partially adjusted is shown by the fact that hospitals received a cumulative increase in the standardized amount of 5.1% over the last five years. The Commission estimates that the amount would have been 7.7% if the update factors consisted of the market basket, adjusted only for coding improvement and site substitution. Therefore, when this 2.6% difference is subtracted from the 8.0% Medicare portion of the differential, the recommended reduction in future standardized amounts is 5.4%.

We have recommended applying this reduction over a three year period, making the average reduction 1.8% annually through fiscal year 1990. The reductions would be one component of an overall update factor for each of these years. Since this recommendation would result in separate update factors for urban and rural hospitals, statutory change is required.

To summarize:

- We started with a difference of 12% between projected and actual costs.
- We agreed that 4% of the difference should not be shared with hospitals and that half of the remaining 8% should be shared equally between hospitals and Medicare (beneficiaries and the government).
- At that point, the reduction would be 8%. We concluded, however, that 2.6% of the difference had already been reflected in relatively low update factors.
- We, therefore, subtracted the 2.6% and arrived at the recommended reduction of 5.4%.
- We recommended the phase-in of the adjustment over three years, or 1.8% per year.

Some have charged that this recommendation to reduce standardized amounts based on first year PPS cost data breaches the basic principles of PPS. They have suggested that it is an attempt to regulate hospital revenue margins. It is neither.

The recommended reduction applies only to future PPS prices -- not to gains previously earned by the hospital industry. A fundamental principle of PPS is that if a hospital's costs for treating Medicare patients is less than its PPS payment, the hospital keeps the entire difference. This principle is not violated by our use of cost information as one factor in recommending the level of future prices.

While the Commission reviewed data on hospital revenue margins, and in fact testified before you in February about our work in this area, we did not directly factor this information into the 5.4% figure that I have been discussing. The Commission does not believe that PPS prices should be set to achieve a particular average revenue margin. If all other factors were unchanged, the adjustment to the standardized amounts would lower PPS margins. But hospitals would still have an opportunity to increase revenue margins by further reducing costs.

Other Update Factor Allowances

After accounting for changes in the standardized amounts which I just described, the Commission recommends that the update factor next consider: changes in the hospital market basket; a

discretionary adjustment factor (which we often refer to as DAF); and, adjustments related to increases in the average DRG weight, or case-mix index, during fiscal year 1987.

The hospital market basket -- the measure of the price of goods and services purchased by hospitals -- is currently estimated at 4.9%. Turning back to the table on page 4 of the statement, you will see that we have added this projection to our update factor for fiscal year 1988.

The discretionary adjustment factor, or DAF, is calculated by using allowances for scientific and technological advancement, productivity change, site-of-care substitution, and real case-mix change. In the table, you will see that the Commission recommends a 0.8% reduction to recognize scientific and technological advancement, productivity and site-of-care substitution. This 0.8% reduction includes: a positive 0.5% adjustment for scientific and technological advancement, reflecting the need to adjust payment levels upward to account for new advancements in medical practice; a negative 1% adjustment to reflect our belief that hospitals should continue to strive for additional efficiency in producing hospital services; and, a negative 0.3% adjustment for changes in the site of care from the inpatient to the outpatient setting.

Following these factors, we assess changes in real case-mix, or change in the complexity of Medicare patients treated in the hospital. We estimate that a positive 1.3% should be added to the update factor to take into account these real case-mix changes.

These adjustments result in a total discretionary adjustment factor of 0.5%. To complete the update computation, we subtract our estimate of total change in the case-mix index for fiscal year 1987, or 1.3%, which will occur in the process of recalibrating the DRG weights. The result is an update and case-mix adjustment of 4.1%.

I would like to point out that the matter of distinguishing between real case mix change and coding improvements has been an especially difficult component of our update factor recommendation for several years. Based on preliminary evidence, however, the Commission believes that these components approximately offset one another and that the case mix change phenomenon is diminishing in its importance to calculating the appropriate update of PPS prices. Nevertheless, the Commission also believes that this phenomenon bears watching carefully in the future and that it is appropriate to devote substantial resources to understanding case mix change better than we currently do.

After applying the average adjustment to the standardized amounts which I described as our first step, we reach the Commission's recommendation of an average total change in PPS prices of 2.3%: 2.2% for urban hospitals and 3.0% for rural hospitals.

While we stand firmly behind this recommendation, I want to remind you that we continue to be concerned about the distributional consequences of all of our actions in updating and changing the prospective payment system. Thus, I want to stress that a number of our other recommendations are just as important as this one.

Earlier Availability of Cost Data

The Commission strongly urges the adoption of the sampling strategy we have developed to speed up the availability of Medicare Cost Report data. There is a critical need for more timely information for decision-making. This need is clearly demonstrated by the debate and discussions over the past weeks

concerning the differential between actual and projected first-year PPS costs, and hospital operating margins. The Medicare Cost Reports provide important information for developing the annual update factor, for assessing the relationship between PPS payments and costs, and for analyzing the costs of individual DRGs.

Our proposal calls for the routine collection of Medicare cost data from a sample of PPS hospitals whose accounting years begin in the first four months of the Federal fiscal year. The current delay of about two years in obtaining complete cost reports results in part because most hospitals have accounting years that begin after the start of the Federal fiscal year. Because hospitals have 3 months after the end of their (not the Federal) accounting year to submit cost reports, long delays are encountered in developing a complete set of cost report data. We believe a sampling scheme could reduce this delay by at least eight months.

The details of this recommendation are included in our report. More details about the analysis upon which it is based are found in the Technical Appendixes to the report. We would be pleased to work further with you and your staff on our proposal, because we believe that Congressional decision-makers would be well-served by adoption of this recommendation.

Update Factor for Excluded Hospitals and Units

Based on current market basket projections, the Commission is recommending a fiscal year 1988 target rate of increase of 4.4% for facilities and distinct-part units excluded from PPS. This target rate of increase factor, separate from the PPS update factor, is used to update the group of psychiatric, rehabilitation, and long-term care hospitals and hospital distinct-part units excluded from PPS. As you recognized in legislative change last year, we feel strongly that a separate update factor is appropriate and necessary for these hospitals whose incentives are quite different from PPS incentives. A detailed description of our deliberations and recommendation are included in the report and the Technical Appendixes.

Incorporating Capital in PPS Payments

The Commission remains convinced that the transition to incorporate capital into PPS should be initiated in fiscal year 1988. We continue to believe that the payment system should be based on a single, all-inclusive PPS rate. We recommend a transition to Federal capital payments be phased in over ten years for fixed capital, and phased in over three years for moveable capital. Until the start of the transition to an all-inclusive PPS payment rate, we have recommended supplemental payments to hospitals for capital costs incurred at other facilities. These costs are not currently reimbursed by Medicare. Finally, we have recommended the development of an exceptions policy to assist certain hospitals that are vulnerable to financial hardship when capital payment is included in PPS.

Improving Hospital Labor Market Areas

In its previous reports, ProPAC recommended improving the way hospital labor market areas are defined. These definitions have a substantial effect on the distribution of hospital payments through their impact on the area wage index adjustment. This distributional effect has critical implications for many hospitals. In this year's recommendations, the Commission provides specific advice for improving the definitions.

Based on its analysis, ProPAC recommends a specific methodology for recognizing wage variation between central city and outlying metropolitan areas, and between urbanized and nonurbanized rural

counties within each state. In addition, we have recommended periodic updating of hospital wage data so that the area wage index will be based on reasonably current information.

Rural Hospitals

The Commission has also amplified its prior concerns about the treatment of rural hospitals under PPS. Despite some technical improvements in payment calculations benefiting rural hospitals, we continue to be concerned about the welfare of beneficiaries who rely on isolated rural hospitals for Medicare services.

We have therefore recommended specific modifications to the way in which adjustments for volume fluctuations are currently paid to some rural hospitals under PPS. The Commission believes that such adjustments should be made available to all hospitals that meet the criteria for designation as Sole Community Hospital, not just to hospitals that apply for and receive this designation. We also believe that the process for obtaining a volume adjustment should be clarified and simplified. In addition, we continue to urge that basic payment issues related to the impact of PPS on rural hospitals ought to be evaluated, and we urge the Secretary to complete and publicize findings from the studies mandated by law on this subject.

Beneficiary Concerns

The Commission is concerned about the financial impact of PPS on beneficiaries and on quality of care. We applaud the efforts of the Congress last year to moderate the increases in Part A hospital deductible. However, we believe that the portion of inpatient hospital payment borne by Medicare beneficiaries, which has risen as a result of length of stay declines under PPS, should be further reduced and returned to its pre-PPS level. We also urge a comprehensive evaluation of the findings from Peer Review Organization (PRO) review of quality of care under PPS.

Improvements to the DRGs

The Commission believes that the DRG system is still the most appropriate available measure of hospital case mix for PPS. We recommend several specific refinements to the DRG system that can be accomplished by making better use of currently available data. We also believe that it may be desirable to develop longer-term improvements in case-mix measurement by incorporating new data that are not currently collected as part of the discharge abstract. To address some of the inherent deficiencies of case-mix measures, the Commission believes that current outlier payment policy should be evaluated and refined to reduce the financial risk associated with caring for extremely costly cases. In addition, we recommend general improvements in DRG classification and specific changes to reflect technological change.

Conclusion

Before I conclude my formal testimony, Mr. Chairman, I would like to thank you and members of the Committee again for your interest in our work, and for your strong support for the Commission and for the analyses we have undertaken in the three years of our existence. We are often asked if we believe that the Commission has had an impact on the PPS system. That is a difficult question to answer with certainty; but we hope and believe that our work is useful, and that it adds to the basic information which you and others need when it comes time for you to vote.

We have been pleased and encouraged that you and your staff have asked for our assistance and used our analytic work, and that many of our recommendations have been reflected in recent reconciliation legislation.

Please be assured that Commission staff will continue to strive to assist in providing timely analyses and information. The Commission itself will continue to attempt to reach judgments which are tempered with as much wisdom as we can collectively muster.

We would be glad to answer any questions you or members of the Subcommittee may have.

Chairman STARK. Thanks, Stu. I am sorry I had to miss part of your testimony.

But let me ask you, just to elaborate a little bit on the beneficiary problem and how it is that they are picking up a larger piece than——

Mr. ALTMAN. Well, as you know, when the original law was passed the deductible was a function of the average per diem rate, and there was a calculation for the whole country on an average. And it made some sense; it was simple and you could understand it.

As you moved to the DRG system and the length of stay per hospital admission fell, the per-day rate naturally went up. But the per day rate doesn't mean anything because we are now paying on a per admission. So the first thing you did was to adjust the deductible to get that out of the system. Now we are recommending take a look at those coinsurance rates that are after the 60th day and after the 90th day.

Chairman STARK. Now that leads me to my next question. What deductible did you recommend, do you recall?

Mr. ALTMAN. We had recommended that you recalculate the deductible.

Chairman STARK. What first-day rate did you recommend?

Mr. ALTMAN. Yes. We had recommended that you recalculate the deductible based on the same proportion of the cost today as it was pre-PPS, and you have not quite reached that. We would have to figure out—there is no one number. It is the technique for doing it.

Chairman STARK. However, if the Gradison-Stark proposal prevails, the copays will be moot, will they not?

Mr. ALTMAN. As they move to—your catastrophic proposal, they would be changed—yes.

Chairman STARK. It would be eliminated, so that would take care of your——

Mr. ALTMAN. Well, that would—yes, that would take care of it. It would change it. Yes, it would take care of it in a different way than we are recommending.

And by the way, what we are suggesting is not inconsistent with that at all.

Chairman STARK. I beg your pardon?

Mr. ALTMAN. It is not inconsistent with it. I said that without regard to the catastrophic we need to make a change.

Chairman STARK. You answered the principal question on developing a uniform reporting and accounting system I think. You are talking, however, about a sampling procedure, are you not?

Mr. ALTMAN. I want to distinguish between that. What I suggested early on was a sampling procedure and a quick response for giving us some feel for what the costs and revenues are during a particular year. That is different than the issue of developing or supporting the continuation of the cost reports.

We are looking at that. It may be that given the kinds of information we need, the old cost reports are not appropriate. On the other hand, it seems pretty clear to us that we do want good information. I don't think we want to create more information than we need, and there was some concern that a lot of the information that was collected was a lot of numbers but not good information.

So we are going to be studying that next year and will be bringing a recommendation before you next year.

Chairman STARK. Wouldn't income information added to the cost reports make sense for us as we try to deal with issues of disproportionate share and teaching hospitals?

Mr. ALTMAN. I personally think so. Again, it is a big leap to have a hospital-by-hospital detailed set of both income and expenses, but I can appreciate what you are saying, and as we move forward in this system and try to bring about equity, try to bring about a targeted response to serious problems, I don't know how you can do it without more information of the kind you are suggesting.

Chairman STARK. Mr. Gradison?

Mr. GRADISON. Mr. Chairman, I want to pick up, if I may, on your last question. My recollection, which I was just checking, is that in the late 1970s or thereabouts there was a proposal from HCFA to require common accounting standards, and the industry went up in smoke about it and I don't believe it was ever implemented.

Mr. ALTMAN. Yes, sir.

Mr. GRADISON. So I am not quite sure how useful the data will be if it is submitted on a basis of different accounting assumptions. The chairman's example of the banking industry may not fit here simply because the banks are required to use a common set of accounts as part of the regulatory scheme, but we don't have that here.

You think that this is a sufficient—that this possible difference in accounting systems is sufficiently serious that if we do have your speed audit the data may not be useful for management purposes?

Mr. ALTMAN. I remember very well the debate in the late 1970s about the SHUR, I think it was called, the report.

Chairman STARK. What was the report called?

Mr. ALTMAN. SHUR, for something, something, something—I don't remember.

Chairman STARK. SHUR—S-H-U-R. Okay.

Mr. GRADISON. System for Hospital Uniform Reporting.

Mr. ALTMAN. Thank you. I think the world, the non-Medicare world has changed a lot since the late 1970s. I may be wrong, Mr. Gradison, but my feeling would be that business and labor and all other payers are much more concerned today with what they pay for in the hospital than they were in the 1970s. What I understood part of the problem with that report was, is that there was substantial objections to introducing such a complicated system either for Medicare or imposing it across the board.

I would suspect that there would be much more of a willingness on the part of other payers and the hospitals—now they can speak for themselves—to get together to try to find what is an appropriate set of information. I don't think you should impose a very tight system only for Medicare which is inconsistent with everybody else. But I find it hard to believe that the other payers are not just as anxious to know what they are paying for as is the Medicare program.

So 1988–89 is different. When you talk to General Motors, for example, they are as concerned about costs as the Medicare program, if not more.

Mr. GRADISON. I remember at the time looking over the system of accounts that was proposed—it was a notebook about yeah thick—and it did raise questions as to whether some institutions would have to keep their books two different ways. They may have certain requirements, for example, under lending agreements with regard to the accounting systems that might be necessary, and those might, conceivably—probably are different from those that a regulator might want in a number of ways.

But leaving that aside, I think the point is we need better data, and we will pursue this with Dr. McCarthy. I would like to inquire with regard to your proposal on the urban-rural differential. Do you feel that the change you are recommending, if implemented, would be sufficient to correct in overall terms whatever distortions exist in the system between those two broad classes of hospitals or is this just a partial step that might require further action in the near future?

Mr. ALTMAN. I am not prepared and I don't think the Commission is prepared to say that if you implement these recommendations you will not have to deal with this problem again. I think we have been trying to move cautiously. We don't know all the reasons. And some of the reasons are justified, so we have taken one step at a time and have on our agenda some further analysis for next year.

So, no, I can't say for sure that this is all that is necessary. But I believe that if you do it you will do no harm and could—well, I shouldn't say that. Let me back off.

There will be differences of opinion on, for example, breaking the wage rates between the urban-rural and the rural-rural because there are going to be winners and losers. So you need to look at that. So I can't say we will do no harm. We believe it substantially improves the distribution of those costs. But there will be some districts which will see a reduction in their payment.

I don't believe we are ever going to have the DRG system in a situation where we can just leave it alone for 5 years and come back and feel that everything is fine.

Mr. GRADISON. Oh, I understand that, and I agree with you. Let me just briefly restate the question to make sure I understand your response. Is your proposed correction adequate to deal with the differences as they exist today, recognizing they may be different a year from now?

Mr. YOUNG. We do have some information on that. From a point of view of the 1981 data that set the payments and the 1984 first-year PPS actual cost, I think the answer is yes to that point.

We also know that originally the difference between the urban and rural standardized amounts was about 25 percent. The changes you made last year in regard to the outlier pool and the discharged weighting reduced that to about 17 percent, or it will when the second half is effective October 1.

Our recommendations for a separate update factor when they are phased in over the three years, will go further to reducing that to a 14 percent differential, so that that differential will be reduced

and it will reflect the world as of the first year of PPS. So to that extent, I think the answer to the question is yes.

Mr. GRADISON. Thank you for that clarification.

Finally, on the subject of capital, it seems to me when we started talking about capital there were two goals in mind, not necessarily inconsistent. One was to incorporate capital reimbursements into the PPS system in order to avoid distortions in management decisions which might be influenced by having one category that was capital which was reimbursable on a cost basis and everything else, the operating expenses on a fixed payment.

The second objective, I believe, was to slow the flow of capital into the hospital industry, the feeling being on the part of HCFA, as I understood their objective, that there was just too much capital going in and that that excessive flow of capital was reflected in excess beds and so forth.

Certainly the first objective isn't met by our 3½, 7, and 10 percent. But there is some evidence that the flow of capital into the industry for whatever reason is declining, and I just wondered what you would think about the proposition that we ought to stick by the 3½, 7, 10 percent, and whatever that might be, presumably a higher number afterward, and declare a victory or do you think we ought to still continue to scrap about this issue?

I should also, as a footnote, indicate that I am satisfied that many people in the industry have been working diligently to come up with a plan, and I wish them well. But I think it is almost impossible for them to come up with something that meets this budget goal and satisfies all of their constituents.

And I don't mind giving them the opportunity, but I hate to have them spin their wheels for 2 more years and end up right where we are today if it looks like it would be better just to stay with these flat percentages.

Mr. ALTMAN. Well, if you will excuse me, I think the plan that you now have is the worst of all worlds. You have a system where you are paying costs but not paying costs, so for some that don't need it but want to spend it, you are going to give them more; and for those that really need it all, you are not going to give them all.

Mr. Gradison, I don't know really know what is going to happen in capital in the long run. The numbers that I see now indicated in 1985 there was the largest increase in tax-exempt financing by a factor of three times. Now there are a lot of reasons for it. The idea was the window was going to close and stuff like that.

It is not surprising that in the next year there is a slowing, or a catching of breath. So the idea that people are coming in and showing you reductions in the next year, I wouldn't use that as anything for projecting the future. I don't know. Maybe it will hold. I don't think they know.

If you want to just take the two numbers and average them, I suspect you are going to find a higher number than in the previous year. So, if you believe in the importance of long run economic incentives, if we keep that differential in place for 10 to 20 years, I have to believe that if we continue to tighten down on the DRG payment system for operating costs and continue to allow a capital cost-based system over time we are going to do just what we did in the 1970s with respect to section 223 limits.

I have kidded about this. We are going to create mechanical nurses. We are going to figure out a way to capitalize a whole series of activities that are now carried out by labor. We did that when we controlled only routine costs, and the result was that there was no more routine hospital care left by the end of the 1970s because the accountants had created everything as an ancillary service.

Now I was kidding about the mechanization of nursing, but they will do it. So I would want to include capital and do it fairly—I don't think we ought to be punitive about it. But if we are going to have a DRG control system on operating costs, you have got to bring capital in, I believe.

Mr. GRADISON. Gosh. I am worried about a blind machine.

Thank you very much.

Chairman STARK. Mr. Coyne?

[No response.]

Chairman STARK. Mr. Pickle?

Mr. PICKLE. Dr. Altman, ProPAC made its recommendation to the Secretary. When was that recommendation made?

Mr. ALTMAN. Technically, the recommendations went up today. But our last meeting was public, so they knew about them in that way. We also went up and, as Bill Roper said, I gave him a briefing on our recommendations.

Mr. PICKLE. So they were aware of the recommendations and figures. I am just trying to establish the sequence in my mind.

You are asked, almost as if you were an arm of Congress, to give your recommendations, and you have made that report to the Secretary. You didn't do so until today, at the same time that the Secretary announced what his recommendations were. You are announcing your recommendation on the same date, almost the same hour. It seems rather odd that HCFA has made its recommendations the same day that you were supposed to make yours. But you had given them to HCFA earlier, about 2 or 3 weeks ago?

Mr. ALTMAN. Yes. We tried to provide them as early as we could.

Mr. PICKLE. Yet now you have recommended a figure higher than theirs?

Mr. ALTMAN. 2.3, on average.

Mr. PICKLE. A little higher figure, both rural and urban. The Secretary recommended a 2-percent increase. Do you agree with their recommendation of 2 percent? Do you consider that the minimum or do you still feel strongly that your figure is correct? Will you accept the 2 percent? Do you have any comment?

Mr. ALTMAN. I don't know what to say about the 2 percent because, first, I had never heard it before today. And second, I don't know where it came from. I think we have tried to lay out every step in our assumptions and tried to show how we reached the 2.3, and honestly, I think that we have attempted to estimate most of what Dr. Roper said we should have. We have tried to estimate what the hospitals have been asked to pay back in previous update factors. We have estimated scientific and technological advancement. So we have gone through all of the steps. So I am very comfortable with sticking with our recommended 2.3 percent.

Mr. PICKLE. You advocate 2.3 and they recommend 2. If this committee were to go down to 1 percent, the other direction, how would you feel about that?

Mr. ALTMAN. Well, I am sure Dr. McCarthy is going to tell you, you are dealing with an industry. You can choose any number you want and in the short run its impact will probably be very little. But over time what you are doing is taking capacity out of this industry. I can't say, and I suspect nobody can say, exactly what impact it would have, but over time I think, if I can use an analogy, I think you would be doing for the health industry what we did for the education industry in this country.

Mr. PICKLE. Dr. Young, do you want to comment on that?

Mr. YOUNG. No, I have nothing to add.

Mr. PICKLE. Well, I think we are approaching this thing from a budget standpoint rather than factually deciding what the figure ought to be. That is unfortunate, times being what they are. I hope, though, that we will listen to those who should know and who are advising us, rather than just take an arbitrary figure.

Mr. ALTMAN. We did not use a budget figure. We didn't look at it and say we have to reach a certain budget number.

Mr. PICKLE. I understand. Thank you very much.

Chairman STARK. Mr. Donnelly?

Mr. DONNELLY. Dr. Altman, you have made some recommendations on capital, but no recommendations on direct medical education payments.

Mr. ALTMAN. Yes, sir. We did not. We did not look this year at the issue of medical education, either direct or indirect. We had been partly involved in discussions the year before when the law was changed to phase the indirect down from the 11 point. So we do not have a recommendation on direct or indirect medical education payments this year. But we do plan to look at it for next year.

Mr. DONNELLY. Beyond last year's?

Mr. ALTMAN. That is right.

Mr. DONNELLY. Beyond last year's.

I don't want to beat the issue of capital to death. You have articulated your feelings on it very well. But you are recommending, as I understand it, a 10-year phase-in for fixed capital and a 3-year phase-in for movable capital.

Mr. ALTMAN. Yes, sir.

Mr. DONNELLY. Why the differentiation in years?

Mr. ALTMAN. Well, movable equipment is mostly machinery which has a much shorter useful life. The obsolescence and depreciation of those types of equipment comes much faster, whereas a building becomes obsolescent over a much longer period of time, and it takes much longer to plan for it. So we tried to put the phase-in more in line with the use life of the equipment.

Mr. DONNELLY. But what is the rationale of the 10-year period for fixed capital? How did you arrive at 10 years versus 5, 6, 7? Was it a negotiated compromise amongst the members or was there analytical data behind the decision?

Mr. ALTMAN. Both. There is nothing magic that I can say if it was nine the world would collapse, and if it were 11 something else would result. We ran a whole series of simulations dealing with a variety of different types of hospitals and their capital flow to see

what would happen under different plans—which hospitals would be winners and which ones would be loser, whether they could pay back the bonding, and so on.

And 10 years was long enough for most hospitals to be able to adjust and not so long that you are waiting forever to phase-in a plan which we thought was justified. So there is nothing magic about 10 years. It is just a Commission's best judgment on what is a fair and equitable transition.

Mr. DONNELLY. Explain to me how your recommendation on the exemption process would work.

Mr. ALTMAN. The exemption process. For capital?

Mr. DONNELLY. For capital.

Mr. ALTMAN. Well, we had a bit of a discussion on that issue. There are those members of our Commission who felt that it was inappropriate for us to have any appeals because once you open that door, no matter how small the crack, the system will just break through it.

I am somewhat sympathetic to that view. On the other hand, the majority of the Commission, including myself, felt that you could not implement such a complicated, far-reaching change with a mechanical formula and then back away and say, "Tough."

Therefore, what we did in our recommendations is to say several things. First of all, there ought to be a fixed amount of money in this pool. Second, the rules ought to be written fairly tightly.

Mr. DONNELLY. A fixed amount of money in the exemption pool?

Mr. ALTMAN. Right.

Mr. DONNELLY. Okay.

Mr. ALTMAN. So that you are not dealing, a dollar given to hospital X is taken away from Y. So that the group that has to do it is going to have to balance these demands.

Second, that the Congress should write a series of very specific guidelines on the qualifications or the requirements for receiving an exception. And then hopefully turn it over to people who would be Solomon-like in their deliberations.

But that even though it was complicated——

Mr. DONNELLY. Who would be those people? Not HCFA, pray God.

Mr. ALTMAN. I don't think I should comment on that.

Mr. DONNELLY. Did you make a specific recommendation?

Mr. ALTMAN. No. We left that up to you.

Mr. DONNELLY. There are too many good lines. I will leave it at that. Thank you.

Chairman STARK. Stuart, thank you. Do you believe that there are, out of the 6,000 hospitals, more than 60 that would not have a computer terminal some place in the hospital?

Mr. ALTMAN. You think there are 60? I find in this day and age it is hard—I am sure there are 60, but it is hard to imagine that a modern hospital today does not have one computer terminal.

Chairman STARK. And a telephone.

Mr. ALTMAN. And a telephone.

Chairman STARK. So there really is nothing in the way of our collecting some data, electronically——

Mr. ALTMAN. Well, I am sure that Carol McCarthy, and the others will tell you, that the part of the cost that is the easiest to

incorporate would be the computer terminal and telephone. What is more complicated and debatable is what you put into that computer, and how you collect that information.

But I am sympathetic to it. I find it hard to believe that we are going to continue this program for as long as I think we should, without increasing our knowledge base.

Chairman STARK. Thank you both very much, and we will need your assistance in the next couple of months as we try and reach a conclusion on this.

Mr. ALTMAN. We will be glad to provide it. Thank you.

Chairman STARK. Thanks a lot.

It is the Chair's intention to work through lunch. The committee has a markup at 1:30 and we will try to take a short break before that time.

Our next witness is Dr. Carol McCarthy, president of the American Hospital Association, which I believe represents all of the hospitals in the United States.

Dr. McCarthy, your statement will be made a part of the record in its entirety, and would you like to proceed to summarize or expand on it, or comment on previous testimony in any manner that you prefer.

STATEMENT OF CAROL M. McCARTHY, PH.D., J.D., PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Ms. MCCARTHY. Thank you, Mr. Chairman.

First, let me say how pleased I am to have this opportunity to share with you at this point in your deliberations some evaluation of the materials that are included in the ProPAC report.

You have before you some extensive testimony and I hope it will be helpful in reviewing the 28 different ProPAC recommendations. I would just like to stress three areas in my verbal remarks—adequacy, equity, and some comments on capital.

On the adequacy issue, for the past several weeks the focus has been on rebasing. I need, then, to address that first, and say that the American Hospital Association, on behalf of hospitals in this country, strongly opposes rebasing, both in principle and because of some practical considerations.

The principle is important. PPS is not designed as a cost-based system. It is a system whose focus is improved efficiency. If we move in a rebasing approach we are putting hospitals in double jeopardy.

We are saying, first, keep your costs within the price we gave you, and secondly, we are holding you to the cost-reporting accuracy of the effect of productivity, intensity, and case mix.

And despite the comments by the prior witness, I really do not believe that when you adjust the cost, or when you adjust for cost in the future, that your adjustment is any less a recognition of cost and a step away from price.

Chairman STARK. Could I raise a question?

Ms. MCCARTHY. Sure.

Chairman STARK. Your comment might be well-taken if we were indeed on a Prospective Payment System, but it is my understanding we are not. We are still with one shoe on, and one shoe off. We

are part cost reimbursement, are we not, and part prospective payment?

Ms. McCarthy. The area that we are discussing today, in the operational cost, is prospective payment, and what is being proposed to you is that we turn away and change that back into cost-based payment. And that is a big step to take.

You are giving a message about the Prospective Payment System that I am not sure you would wish to give. Let me talk the practical side.

There is a saying that if you torture the numbers enough, they will confess. Well, we have spent the last four weeks torturing the evidence that is available, and you cannot get that evidence to confess a Medicare profit margin of between 12 and 15 percent. Therefore, how do we have the figures, and what do we do with them? What we have are estimates based on the cost reports.

The problem that we have is how accurate the cost reports are. We have been talking a lot about data and its availability. What is available is an indication of what total patient revenue margins were in the past.

We have them for 1983; we have them for 1984. Those patient revenue margins, and even total margins, would have to have increased 5 percent in 1983 and 1984, if we are to believe that there were Medicare profits of 12 to 15 percent.

In fact they increased at 1 percent. The bottom lines do not support any estimates of Medicare profits between 12 and 15 percent.

When we last spoke on the profits, we said, well, is it perhaps due to discounting in the private sector? So we took a long look at that.

Net private patient payments compared to the charges do not fall commensurate with Medicare margins of 12 to 15 percent. The best you can account for in looking at discounting in the private market is a margin of somewhere between 2 and 5 percent. So discounting was not the answer.

We took a look at coding because the last time I was with you and testifying, you asked me about that. You said what about upcoding? Isn't that part of the profits?

If you look at the Medicare payment ratio, what are Medicare charges, and what were the Medicare payments, and how did they change together? All right. Did we get many more payments from Medicare at the time we held our charges relatively stable?

You can find, between 1983 and 1986, a rise in Medicare payments as a percent of charges, of about 5 percent. And I submit to you, that that is the upper limit for any upcoding between 1983 and 1986.

It is probably a little less, because the charge factor also includes factors for utilization and productivity. But at most, it is 5 percent.

If it is not due to upcoding, and it is not due to discounting in the private sector, and it is not due to reduced intensity, is it due maybe to the fact that the cost of treating private patients rose sharply while the cost of treating Medicare patients declined sharply? I mean, how do you get a margin?

Again, the data do not show that either. The data show that Medicare and non-Medicare costs rose relative to one another.

What we do have is support for Medicare margins between 5 and 6 percent in 1984, and that the difference between 5 and 6 percent is an artifact of the Medicare cost report.

If you look to the modest updates in the Medicare prices, since we began, and the margin of 5 to 6 percent, it is not surprising that you come out where we are today, and that is with a patient revenue margin of six-tenths of 1 percent.

Otherwise, the figures make no sense. So, we should not begin to rebase on figures that are not supported by patient revenue margins, total revenue margins, and changes across industry.

Chairman STARK. Doctor, we do not have those figures. We do not have any revenue figures. You have them but we do not.

Ms. MCCARTHY. Well, we would be happy to supply to you those figures.

Chairman STARK. I mean, those just are not part of the ballgame. That is part of our problem, but I am just suggesting to you that we do not have revenue figures.

Ms. MCCARTHY. Mr. Chairman, we can supply to you aggregated figures. We could not supply to you individual hospital figures, but we could supply them to you, aggregated at whatever level.

In addition, the Medicare cost reports include hospital financial statements. Those are submitted as part of the Medicare cost report. The information is available, and the information does not support that kind of a profit level.

What about the update factor? ProPAC's recommendation is really for 4.1 percent. If you remove their rebasing suggestion, they are recommending that prices be increased 4.1 percent. That is about one-half percent, a little more than that, under market.

We believe that you have a justification for actually going a half a percent over market, and I think it is important, even given the Federal budget deficit, for me to just share with you what is out there, and what in fact could be supported as an appropriate price update. I am just going to concentrate on where we diverge from ProPAC.

ProPAC suggests reducing rates be 0.3 percent for site substitution. We are talking of marginal cost, days of hospital care avoided. Those days avoided are the least costly days. We do not believe that if you take a look at where we are today, if you translate the least costly days, or the marginal cost factor, you would have a justification for reducing prices for site substitution.

We are not recommending a reduction for upcoding, for the reason that I went through earlier. The most that we can come up with as an upcoding figure is 5 percent. Three percent was taken out of the Medicare program before it even began for upcoding, leaving us with two. We have had a 6.4 percent reduction below market since the PPS program began, more than sufficient to correct for any upcoding.

So, we are certainly not, again looking ahead, suggesting there is an upcoding factor. And finally, productivity.

ProPAC recommends a reduction of 1 percent. We are suggesting that there are no data to support more than a reduction of a half a percent.

The data to be had on productivity are largely data on staffing per patient day, on resource consumption, and on treatment intensity.

We can demonstrate a moderate increase in productivity, but only if we assume that all case mix changes were real, none of it was upcoding.

If we do that, and correct, we can show a modest increase in productivity in both 1984 and 1985. The statistic that gives us some concern, as we look ahead for what is happening in the hospital system, is an 8 percent increase in staffing in 1986. That is about seven times the situation in 1985.

When you couple that upstaffing with the cost picture, what we are concerned about is that you now have reached the point by treating people in the least costly setting, whenever we can, that we have got an intensely ill group of people left, and we are upstaffing to take care of that.

So we would say, don't go in that price adjustment any lower than a one-half of 1 percent down adjustment.

That brings you, if you will, to a way to base hospital prices in the upcoming year by adding on a factor that is one-half percent above market.

Equity adjustments. We would recommend that you adjust the price update—and that is why it is important to give a fair update—that you differentially adjust it for urban and rural hospitals. That you, in effect, decrease the update for urban hospitals by about 0.7 percent and use that amount to increase the update for rural hospitals by about 3.5 percent. This will reduce the urban-rural differential.

We are also asking for an exceptions process as ProPAC is, a tightly drawn one. We do not want you to have 5,600 facilities in for exceptions. A tightly drawn process. But we think you need one to look at differences in the labor index, the nonlabor index, and the rural referral center question.

We have tried to do the study that ProPAC is suggesting on the labor index. We have worked exceedingly hard. We took four different approaches to it, because there are in fact differences in labor costs in the urbanized and rural sections.

The difficulty is, however, that these approaches are not sensitive to the individual hospital labor market. So that when we make the adjustments, we are still not addressing that individual market problem. We are creating new problems as we make the adjustments.

And the only way, therefore, we can see to take into account the very real fact, that what we have does not work, is the exceptions process, for now, and continue to work on the system.

In the nonlabor area, it is the same thing. There are some marked nonlabor differences across regions, and across States, and within States. Here we are having a problem because of available price information. That is really what we ought to be using to fix nonlabor purchasing, and until we have price information that is reliable for a systemwide change, we believe you need to open up the issue of nonlabor costs at a hearing.

We support the changes for the sole community provider, although our testimony goes a bit differently from ProPAC's. We

have a recommended change in the way you would reimburse sole community providers, that we believe would address the particularly tight straits those facilities find themselves in.

And also on equity, we would ask that you continue the indirect medical education adjustment, and that you implement no changes in the direct medical education adjustment until the changes that have been recently passed are at least fully implemented and we have a chance to know what the impact of that is.

And finally, capital. The interest of the American Hospital Association, from the very outset, has been in a capital payment system that is both adequate and equitable, largely because capital cost are very different from operating costs. They are committed costs. They will remain, no matter what changes we make in the payment for them.

We have taken a look at the proposals that are currently being circulated, and none of those proposals leads to adequate or equitable payment.

Splitting capital between fixed and movable has one effect: it accelerates the transition to the national rate. In other words, that 10 year does not become 10 year overall. You are accelerating it.

Second, it is very complicated. You are going to have to run two systems for payment for capital, maybe even two outlier pools.

Third, there is the question of the availability of data on what is fixed and what is movable, and information that we have shows a wide variation from facility to facility, as much as from 1.6 percent of all capital being movable to over 45 percent of all capital.

So, I mean, how do we find out—what do we come out with as an average here, that does not truly create gross inequities? But key to all of the proposals, both HCFA's and ProPAC's, is how many hospitals are going to be truly vulnerable?

And the vulnerability study that is included in the ProPAC testimony gives no attention to actual capital costs currently. It concentrates on the average hospital in the average situation, and what we are concerned about with capital is the nonaverage hospital and the atypical situation.

It also starts looking for vulnerability by putting aside those facilities that have Medicare operating deficits. If you will look at page 33 of the American Hospital Association's testimony, you will see our vulnerability index.

We took the actual capital costs that we knew these facilities faced in 1984, and played out what would happen to those facilities, and we used the administration's proposal because it is the less onerous. It is weighted hospital-specific in the early years.

And you will see there a number of different cuts. I share this one with you. Thirty percent of all small hospitals, and 30 percent of all large hospitals would be underpaid at least 10 percent for their capital.

Forty percent of all midsized hospitals would lose 10 percent or more, and 30 percent of these would experience losses of 20 percent or more. So we have got an issue that is much more than 3.3 percent of the hospitals across the United States being affected by this proposal, and therefore we are left recommending to you, that you continue the passthrough until at least October 1, 1989. And again, let's put some more developmental time in.

I do not think we have to worry about inefficiency in the meantime. Hospitals have taken steps—for example—to refinance their capital projects to an extent where there are now limitations proposed on the ability to refinance. One does not do that if there is no interest in bringing down interest costs.

The current passthrough with its 7-percent reduction, and the recognition of capital costs, is also a very strong incentive to avoid any marginal capital investments.

And lastly, with the Prospective Payment System itself, and the inadequacy of the payments a hospital is receiving, there is an incentive to watch capital investment.

Many, if not most, capital projects have associated operating costs, and you cannot just simply build without having the moneys to run. And I would close with one comment on capital.

The history of health care in the United States just does not support the ready substitution of capital and labor, and therefore, I do not think we really have to worry that what is going to happen if we do not immediately incorporate capital into price, is that somehow, we are going to turn all of our labor costs into capital costs, and move through a passthrough route. It just is not what the real world looks like.

I would be pleased to answer any questions you might have.

[The prepared statement follows:]

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STATEMENT OF THE
AMERICAN HOSPITAL ASSOCIATION
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
OF THE
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE RECOMMENDATIONS OF THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION
AND RELATED RECONCILIATION ISSUES

April 1, 1987

SUMMARY

This statement focuses on issues Congress must address in fashioning a FY 1988 Medicare budget and on the recommendations of the Prospective Payment Assessment Commission (ProPAC). Most of the comments regard the adequacy of Medicare payment to hospitals. AHA unconditionally opposes rebasing of the prospective pricing system (PPS), first, because it is a fundamental departure from the original design of PPS, and, second, because adequate factual basis for making rebasing adjustments does not exist. AHA believes cost report data used by ProPAC, the Congressional Budget Office (CBO), and others to justify reductions in prices significantly overstate the actual discrepancy between what it costs hospitals to treat Medicare patients and what Medicare paid for those services. Available data indicate that an appropriate update factor is 5.4 percent, and that the smallest acceptable update would equal the market basket increase. AHA is generally supportive of ProPAC's recommendations for improvements in the DRG system, the treatment of rural hospitals, and beneficiary cost-sharing. Our own recommendations concerning the urban/rural differential, area wage index, transitional care, sole community providers (SCPs), periodic interim payment, disproportionate-share adjustment, medical education, and capital should be enacted by Congress to ensure adequacy and equity of PPS.

INTRODUCTION

Mr. Chairman, I am Dr. Carol M. McCarthy, President of the American Hospital Association (AHA). I am pleased to be here today, representing AHA's 5,600 institutional members, to discuss Medicare budget reconciliation issues, including recommendations of the Prospective Payment Assessment Commission (ProPAC) concerning the Medicare prospective pricing system (PPS).

The issues before this committee are many and difficult. If federal budget deficit targets are to be met, government outlays must be reduced, or taxes must be raised. Yet despite pressures to reduce federal outlays, problems cry out for new initiatives to address pressing issues such as catastrophic illness and medical indigence, as well as the need to sustain prior commitments. Funding must be maintained at a level commensurate with benefits already promised current and future generations of the nation's elderly.

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This hearing will focus on issues Congress must face in fashioning a Medicare budget as well as ProPAC recommendations that will be released later today. Most of the comments that follow regard adequacy of payment. It is unfortunate that the debate over federal health policy so frequently focuses on payment, but payment and financing are basic. Without funds, it is not possible to provide services--as many hospitals whose principal mission involves caring for the uninsured will attest. And so discussions about payment are ultimately about more than money. They are about the type of services that will be available to Medicare beneficiaries and ultimately to all Americans.

FISCAL YEAR 1988 PRICE UPDATE

For fiscal year 1988, the debate over the appropriate amount by which to update PPS prices has in recent weeks come to focus on a single issue, the question whether PPS should be "rebased" to reflect reported costs for the first year under prospective pricing. AHA unconditionally opposes rebasing the system, first, because it is a fundamental departure from the original design of PPS, and second, because an adequate factual basis for making such adjustments does not exist.

Operating Margins and Rebasing

ProPAC has recommended that prices be reduced 5.4 percent over a three-year period, or 1.8 percent per year. The recommended reduction is greater for urban than for rural hospitals: 5.7 percent in total or 1.9 percent per year for urban hospitals; 3.3 percent in total or 1.1 percent per year for rural hospitals. These reductions are in addition to adjustments that have already been made in federal fiscal years 1985 through 1987, and that ProPAC is proposing or may propose for fiscal years 1988, 1989, and 1990.

In arriving at its recommendation, ProPAC relied on estimates of first-year profit margins computed from Medicare cost reports. ProPAC estimates that if actual 1984 costs were substituted for estimates of 1984 costs used in setting prices in 1984, prices would have been about 12 percent lower. ProPAC believes that of this amount 4 percentage points are the result of factors such as site substitution and more accurate coding. The remaining 8 percentage points stem from greater efficiency, and ProPAC believes these savings should be divided equally between the Medicare program and hospitals. Thus, ProPAC believes that Medicare's share of the first-year surplus is 8 percent, the 4 percent due to improved coding and site substitution and one-half of the improvement in efficiency and productivity. However, ProPAC advises that 1987 prices should be reduced 5.4 percent because Medicare has already recovered part of its share of the first-year margin by increasing prices less than the increase in the hospital market basket over the past three years. This reduction is to be phased in over three years, independent of the annual update factor. These calculations are summarized in Table 1.

Table 1: Derivation of ProPAC Rebasing Amount

Estimated First Year Margin	12 percent
Amount Attributable to Coding & Site Substitution	4 percent
Amount attributable to improved efficiency	8 percent
Calculation of Rebasing Amount	
Medicare's share of first year margin	
Amount attributable to coding & site substitution	4 percent
One half of amount attributable to improved efficiency	4 percent
Total	8 percent
Less: Amount already recovered through below market basket increases in prices	2.6 percent
Amount of reduction to current (FY 1987) prices	5.4 percent

Rebasing and the Principle of Prospective Pricing

The proposed rebasing of PPS is inconsistent with its original design, which was an attempt to change behavior through incentives. Hospitals were to devote their efforts and resources to the management of efficiency and effectiveness, not to compliance with cost-reporting rules and regulations. Rewards were to be based on the ability of a hospital to improve efficiency, not its ability to complete a Medicare cost report. The use of cost-report data to reset prices would be a fundamental change in original design.

The proposed rebasing of the system raises two issues of principle. The first regards the extent to which improvements in efficiency should be shared by Medicare beneficiaries, the Medicare program, and hospitals. In general, the approach of setting a reasonable annual update factor entails a sharing of efficiency improvements. If hospitals hold the rate of increase in costs to the market basket, and if prices increase only by the market basket, then the Medicare program receives the entire benefit of improved efficiency. Hospitals participate in improved efficiency only if able to hold the annual rate of increase in their costs to an amount less than the market basket increase. A policy of rebasing ignores the fact that Medicare already has captured a substantial percentage of improvements in efficiency by setting price update factors that are substantially less than the increase in the hospital market basket.

Since the first year of PPS, rates of price increase have been extremely low, as noted by ProPAC in its recommendations: 3.4 percent in 1985, 0.2 percent in 1986, and 1.15 percent in 1987. To the extent these rates of increase are "unreasonable," they are unreasonably low. The reasons given for reductions in the update factor have included productivity improvements, changes in clinical practice, and improvements in coding of diagnosis and surgical procedures. Of these, the principal justification offered for low rates of increase concerns measurement of case mix. If the rising Medicare case mix index were the result of more accurate diagnostic and surgical procedure coding, and not the result of real changes in the mix of Medicare patients admitted to hospitals, then low rates of increase might be justified. The evidence that AHA has examined, however, indicates that although both factors were at work, the reduction in update factors has over-corrected for the improvement in coding.

The ProPAC recommendation on rebasing claims to be based on the principle that improved productivity should benefit the industry, the Medicare program, and Medicare beneficiaries. But the recommendation ignores the fact that the process of setting the annual update factor already ensures that Medicare has and will benefit from improved efficiency. It also ignores benefits that will accrue to Medicare beneficiaries from the improvement in services made possible by improved hospital efficiency and operating surpluses. Moreover, the ProPAC recommendation to rebase the system using first-year cost-report data ignores the fact that implementation of PPS requires many hospitals to make major changes in services they offer and resources they employ. Many hospitals reporting profits in the first year would have experienced losses under a uniform national rate. To avoid losses, these hospitals already had to make significant changes in operations, and further changes in services they offer and resources they employ will undoubtedly have to be made when the transition to national rates is completed beginning with fiscal years starting on or after October 1 of this year. To rebase the system is to further strain these hospitals before the impact of moving to the national rate has been evaluated.

The second question of principle is whether prices should be determined through the process outlined in section 1886 of the Social Security Act as it was enacted by Congress in 1983, or whether prices should be set on the basis of cost reports. The original process was intended to set a reasonable rate of increase in prices. To now introduce cost-report data into the process of price setting puts hospitals in double jeopardy, first for their ability to hold the rate of increase in their costs within the annual update factor, and second for the ability of the cost report to accurately reflect the net effect of changes in productivity, intensity, and case mix on costs. If payment is to be based on cost-report data, what principle will guide use of those data? If prices are to be cut because 1984 data indicate costs were less than payments, will prices be increased if data from 1986 or 1988 or 1990 indicate costs are then greater than payments? Or will rising costs be ignored? If cost reports are to be used only to justify price reductions, rebasing becomes, over the long term, a "lesser of" policy: payments to hospitals will be the lesser of costs reported on cost reports or prices determined under PPS.

The Factual Basis for Rebasing

Although AHA's opposition to rebasing is grounded in the principles discussed in the previous section, practical considerations also argue against rebasing. Rebasing would of necessity rely on inadequate and invalid data. Available cost data appear to be intrinsically flawed, and pertain only to 1984. They have little bearing on costs in 1988. The extent to which costs have increased--and operating margins reduced--is addressed below. A more important question--and one given only passing mention by ProPAC in its recommendations--regards the validity of cost-report data on which reports of "hospital profits" during the first year of PPS rest. If more recent cost-report data are to be used to reset prices, those cost reports must be completed with the same attention to detail and subject to the same policies and procedures that governed completion of cost reports used originally to set prices.

Although ProPAC appears to have been aware of problems associated with using first PPS year cost-report data, no significant effort was made to determine the overall validity of those data. AHA believes that hospitals probably earned a modest surplus in the first year of PPS but that cost-report data used by the Congressional Budget Office, ProPAC, and others significantly overstate the magnitude of those profits. Furthermore, nominal price increases since the first year, combined with changing utilization patterns, have significantly eroded any margins that may have been earned. The role of productivity in producing any margin that was earned, together with changes in productivity since the first two years of PPS, are discussed in a subsequent section of this statement. The assertion that cost-report data significantly overstate the actual first-year Medicare operating margin rests on several pieces of evidence.

- The failure of overall hospital margins to change to an extent commensurate with the reported Medicare margin. If first-year PPS operating margins were as large as claimed by ProPAC or reported on

Medicare cost reports, overall operating margins should have increased more than 5 percentage points between 1982 and 1984 or 1985. In fact, the increase in both patient revenue margins and total revenue margins
was less than 1 percentage point between 1982 and 1984 and less than 1.3 percentage points between 1982 and 1985. Changes of this magnitude would be consistent with a Medicare margin of between 1 and 3.5 percent in 1984 and of between 2 and 4.5 percent in 1985.

- The failure of the ratio of private sector payments to charges to change to an extent commensurate with the reported Medicare surpluses. If the failure of overall margins to increase by an amount commensurate with the reported Medicare operating margin were the result of increased costs or discounting in the private sector, net revenues should have fallen as a percentage of gross charges by an amount commensurate with the Medicare operating margin. Between 1982 and 1985 the ratio of net to gross revenues for non-governmental patients does appear to have fallen between 2.8 and 3.5 percentage points. However, the fact that gross charges rose at a more rapid rate than total expenses partially explains the decline in the ratio. Again, the changes in the ratio of private sector payments to charges suggest that the actual, as contrasted to the reported Medicare margin, was between 2 and 5 percent.

- The failure of the ratio of Medicare payments to charges to change to an extent commensurate with reported Medicare surpluses. If reported profits were earned by either reducing intensity of treatment of Medicare patients or because of improvements in diagnostic coding, the ratio of Medicare payments to Medicare inpatient charges should have changed dramatically between 1983 and 1984. In fact, the ratio did increase, but only 1.7 percentage points between 1983 and 1984 and 5.2 percentage points between 1983 and 1985. This increase indicates that
more accurate coding of claims may have caused an increase in payments of up to 5 percent.

- The failure of Medicare and non-Medicare per case charges to change to a degree commensurate with the reported Medicare margin. The patterns reported above leave as the only remaining explanation of the anomaly of large reported Medicare margins and modest changes in overall margins the possibility that the cost of treating private patients rose sharply at the same time that the cost of treating Medicare patients declined sharply. Overall, however, total charges per case for non-Medicare patients rose 10.7 percent in 1984 and 8.4 percent in 1985. In both years the increase was greater than the increase in hospital charge levels as measured by the Consumer Price Index, indicating intensity of treatment and costs did not suddenly diminish. This pattern suggests that the cost of treating non-Medicare patients rose relative to the cost of treating Medicare patients. Again, however, the relative change would be consistent with a Medicare margin of between 2 and 5 percent, not one in excess of 10 percent.

These data strongly and consistently suggest that profits earned under prospective pricing are largely illusionary, arising as an artifact of the cost-finding process. In fact, a critical examination of the Medicare cost-finding process indentified at least two possible explanations for the change in Medicare costs. The first is the possibility that cost reports completed in the first PPS year understated overhead costs that should have been assigned to Medicare patients, in part because of technical changes in the design of the cost report.

The second reason regards the impact of shorter lengths of stay on the average per diem cost of treating Medicare patients. Medicare's share of routine costs is calculated under the assumption that, on average, Medicare and non-Medicare patients use the same services and incur the same costs each day they are in a hospital. Recent changes in utilization patterns by Medicare and non-Medicare patients render the assumption even more questionable today

than previously. The days of inpatient care that have been eliminated tend to be the lower-cost days at the end of a hospital stay. Thus, shorter stays result in higher per diem costs. As the reduction in length of stay has been somewhat greater for Medicare than for non-Medicare patients, it is very likely that the per diem cost of treating Medicare patients has risen relative to the per diem cost of treating non-Medicare patients.

For these reasons, first-year cost reports should not be used as the basis for adjusting prices.

Annual Update Factor: FY 1988

Although ProPAC has proposed to rebase PPS, its recommendations also address the amount by which prices should be increased before prices are reduced as discussed above. For fiscal year 1988, the annual update factor recommended by ProPAC is 4.1 percent. This factor reflects four assumptions:

- a projected increase in the hospital market basket of 4.9 percent;
- a "discretionary" adjustment for technological and scientific advances of +0.5 percent;
- a "discretionary" adjustment for productivity improvement of -1.0 percent;
- a "discretionary" adjustment for "site substitution" of -0.3 percent;
- a proposed adjustment for "coding improvement" of -0.5 percent; and
- a proposed adjustment for "within DRG" case complexity change of +0.5 percent.

The net effect of the adjustments to the market basket results in a reduction of 0.8 percent, leaving an annual update factor--before rebasing--of 4.1 percent.

AHA supports ProPAC's recommendation for a separate update factor for PPS-exempt hospitals, but we believe that ProPAC recommendations for PPS hospitals fall short of an adequate update factor. Specifically, AHA believes that available data indicate that a more appropriate update factor would be no less than the market basket increase, and that a more appropriate set of assumptions concerning productivity, technology, and case mix would be as follows:

- Productivity. In 1984 and 1985, the first two years of operation under PPS, productivity appears to have risen modestly, but overall by no more than 1 to 2 percent per year. In federal fiscal year 1986, the most recent period for which data are available, productivity may have improved, but by less than half the improvement in the preceding two years. Consequently, the maximum adjustment that should be made for productivity in 1988 is less than one-half of 1 percent.

- Technology. The effects of technology and scientific advances are difficult to separate from the effects of productivity. However, in 1984, the resources consumed by the average hospital patient may have declined nearly 3 percent, but in 1986 the quantity of resources consumed by the average patient rose more than 4 percent. Overall, since the implementation of PPS, there has been little change in the rate of increase in the quantity of resources consumed by a patient over the course of a stay, apparently because of increases in intensity of treatment. Consequently, the ProPAC recommendation on technology should stand.

- Case Intensity. In 1984, the intensity of treatment of patients may have fallen as much as 4 percent, but since then has been rising. On the whole, in the period since the implementation of PPS, intensity may have risen 0.6 percent per year or more. Consequently, the

ProPAC recommendation regarding intensity should be accepted as a minimum increase.

- Site substitution. ProPAC has attempted to correct for changes in the use of post-hospital care but has not offered any information on how that adjustment was performed. Furthermore, the correction for site substitution effectively double counts improvements in productivity. It would be inappropriate to reduce prices paid to hospitals in direct proportion to the increase in payments for post-hospital services for two reasons, discussed below.

- Case Mix Change. Evidence reviewed above in the discussion of rebasing indicates that the amount of change in case mix that may be due to changes in coding is no more than 5 percent. As ProPAC indicates, the rate of change in case mix is now declining. Consequently, no further correction for changes in case mix should be made until more definitive information on the extent of improvement in coding is available.

The AHA recommendations and the ProPAC recommendations are compared in Table 2, below.

Table 2: Comparison of ProPAC and AHA Update Recommendations

	ProPAC	AHA
Hospital Market Basket Increase	4.9 percent	4.9 percent
Technology and Scientific Advances	+0.5 percent	+0.5 percent
Productivity Improvement	-1.0 percent	-0.5 percent
"Site Substitution"	-0.3 percent	0.0 percent
"Coding Correction"	-0.5 percent	0.0 percent
"Within DRG" Case Complexity/Intensity	+0.5 percent	+0.5 percent
Total: Increase in Prices for FY 1988	+4.1 percent	+5.4 percent

AHA's disagreement with ProPAC regards two of the adjustments. The first is for site substitution; the second is for case coding. In addition, AHA believes that ProPAC overestimates the extent to which the combination of rising intensity and productivity will enable costs to be reduced below the rate of inflation.

Site Substitution. As a matter of policy, AHA does not believe that reductions to reflect the reported increase in the use of non-acute services by Medicare beneficiaries can be justified for two reasons. First, within the ProPAC framework itself, the amount of care provided outside the hospital setting should have little bearing on the correction to hospital payments. What is relevant is the reduction in costs that site substitution might make possible at the margin. Thus, the number of days of skilled nursing facility care provided to patients discharged from an acute hospital is not directly related to the adjustment that should be made in prices; prices should be adjusted only to reflect days of hospital care avoided by timely use of a skilled nursing facility. Moreover, the adjustment to the hospital payment should reflect intensity of treatment on days at the end of the stay, for which skilled nursing care is being substituted, relative to intensity of treatment on days that the patient does spend in the hospital. As discussed above, the marginal cost of providing sub-acute hospital care is likely to be relatively low; thus, any reduction to reflect shorter stays made possible by use of nursing homes or home health care should be small.

Second, ProPAC appears to rely heavily on aggregate expenditures for post-acute care. Increased use of post-acute care is probably only in part the result of substitution. One way in which PPS has probably improved quality of care received by Medicare beneficiaries is through more comprehensive discharge planning and better placement of patients in need of post-hospital care. In other words, many of the patients now receiving post-hospital care are probably receiving no less hospital care than previously, but are being appropriately referred to providers of post-hospital care when their stay is completed. Until these factors are more accurately disentangled, no change should be made. The data reviewed above do suggest that early reductions in intensity of treatment that would be associated with site substitution are now behind us, and that continuing changes in utilization patterns may be leading to greater intensity of treatment on balance.

Case Coding Improvements. ProPAC has adjusted the rates to reflect "real" change in case mix across DRGs and "real" changes in case mix within DRGs. Cost weights have been reduced to reflect the change in the overall case mix index, in effect adjusting for both real change and change that is the result of improved coding. However, ProPAC has presented no new evidence on the extent to which changes in coding are responsible for the increase in the case mix index.

The principal conclusion of our own analysis on this issue is that the maximum correction for changes in coding justified by available data is approximately 5 percent. Specifically, in 1985, gross inpatient revenues per case rose 6.9 percent, while net inpatient revenues rose 11.8 percent. The approximately 5 percent gap between the rate of increase in gross and net inpatient revenues is an upper limit for the estimate of the nominal change in case mix during the first years of PPS. It probably overstates the nominal change in case mix because it reflects the net effect of changes in use of services, productivity, and accuracy of diagnostic coding.

During the past three years, the reduction below market basket was approximately 6.4 percent (2.35 percent in 1987, 3.0 percent in 1986, and 1.05 percent in 1985). The amount by which prices have been over-corrected is, therefore, a minimum of 1.5 percent and probably more if adjustments to prices are also made for factors such as productivity. Further corrections would be particularly inappropriate because, as ProPAC indicates, changes in case mix indices appear to have diminished in recent months.

Productivity and Case Intensity. As noted above, since 1984 hospitals do appear to have achieved a moderate improvement in productivity, but only when the increase in case mix indices is assumed to be real and not the result of coding improvements. The evidence of an improvement in productivity is as follows:

- Between 1977 and 1982, the ratio of staff to adjusted admissions rose at an annual rate of 2.5 percent. Between 1984 and 1986, this ratio rose at a rate of only 0.4 percent. The ratio of staff to adjusted patient days rose at an annual rate of 2.7 percent between 1977 and 1982. Between 1984 and 1986, this ratio rose at an annual rate of 1.8 percent.

- This increase in staffing levels may be interpreted as either a reduction in productivity or as evidence of changing case mix and intensity. Corrected for change in case mix, using the assumption that the reported change in Medicare case mix was real and not the result of more accurate coding, the ratio of staff to adjusted admissions acually fell at an annual rate of 1.5 percent between 1984 and 1986. This trend indicates it is possible that hospital labor productivity has probably increased modestly since implementation of prospective pricing.

- The decline in staffing levels was greatest, however, in 1984, and has been leveling off since then. Looking to the future, the fact that staffing levels are beginning to turn upward once again suggests

that case mix and case intensity continue to rise: in 1986, the ratio of staff to adjusted admissions rose 0.8 percent--more than seven times as fast as the increase in 1985. This change was accompanied by a leveling off in average length of stay and a continued decline in the number of admissions. These patterns are consistent with the assumption that changing utilization patterns are resulting in a more acutely ill patient mix requiring more intensive treatment. Assumptions of continued improvement in productivity based on these data would be clearly inappropriate unless accompanied by data and assumptions directly addressing changes in both case mix and intensity.

Available evidence on changes in intensity of treatment was reviewed above in the discussion of rebasing. The key findings bearing on the update factor are as follows:

- Price-level adjusted revenues (i.e., changes in patient revenues adjusted for changes in hospital charge levels) are an indicator of the number and complexity of services received by patients over their stay. Overall, this indicator suggests that intensity of treatment received by hospital patients has increased for both Medicare and non-Medicare patients.

  Between 1977 and 1982, using the hospital room component of the Consumer Price Index to correct for inflation, the number or intensity of services consumed by the average inpatient rose approximately 0.7 percent annually. Between 1984 and 1986, the post-PPS period, the annual rate of growth in the the number of services or intensity of treatment received by the average patient rose to 2.6 percent--nearly four times the pre-PPS rate. If these figures are corrected for changes in case mix, the rate of change in intensity of treatment in the pre-PPS period falls to -0.4 percent and +0.6 percent in the post-PPS period.

  It is possible to distinguish between Medicare and non-Medicare patients only for the period from 1983 to 1985, and these data indicate that the intensity of treatment of Medicare patients may have declined in 1984 and 1985, but that the trend is toward greater intensity. Specifically, in 1984, the hospital room component rose 8.8 percent, compared to an increase in Medicare gross inpatient revenue per case of 6.1 percent, suggesting a reduction in use of services by Medicare patients of 2.7 percent. Similarly in 1985, the hospital room component rose 6.7 percent, while Medicare gross inpatient revenue per case rose 6.9 percent, suggesting a 0.2 percent increase in use of services by Medicare patients. Because changes in the room rate reflect rising intensity and changing case mix, and because much of the reduction in charges probably was the result of changes in average length of stay of Medicare patients, these figures are likely to overstate the reduction in intensity.

- On a per admission basis, price-level adjusted inpatient operating costs rose at an annual rate of 3.3 percent between 1977 and 1982; between 1984 and 1986, these costs rose at an annual rate of 4.3 percent. The acceleration in the annual rate of increase in price-level adjusted costs suggests that the historical trend in case mix changed with the implementation of PPS and/or that the intensity of treatment has continued to rise--possibly at an above average rate.

These figures suggest that changes in productivity and intensity of treatment have leveled off--or moved in offsetting directions. Further adjustments anticipating further change would be inappropriate. A more reasonable course of action would be to make adjustments only after the fact, and to make no prospective adjustment for changes in productivity or intensity given the amount prices have fallen behind the market basket over the past three years. This recommendation, it should be noted, will itself provide Medicare with the savings that PPS was designed to produce. Hospitals do not participate in the

savings produced by improved productivity unless they can hold the rate of increase in their costs to an amount less than inflation.

Conclusions on Rebasing and the Update Factor

AHA does not object to the general principle that productivity gains be shared among the Medicare program, Medicare beneficiaries, and Medicare providers, but believes that setting the update factor at the market basket virtually guarantees such a sharing. An increase equal to the market basket would require hospitals to improve productivity to avoid losses in the face of changing patient mix and intensity of treatment. Moreover, the Medicare program receives the "first dollar" of any improvement in productivity. Hospitals cannot claim their share of productivity improvements unless the increase in their costs is held to an amount less than the rate of inflation.

In addition, PPS-exempt hospitals should be granted a separate update for FY 1988 of no less than the market basket.

On the issue of rebasing, AHA believes that available data indicate that cost-report data used by ProPAC, the Congressional Budget Office, and others to justify significant reductions in prices significantly overstate the actual discrepancy between how much it cost hospitals to treat Medicare patients and what Medicare paid for those services. A more reasonable estimate of first-year operating margins would place them no higher than 5 to 6 percent, and reductions in the annual update factor since then have virtually ensured that those margins have been eliminated.

More important, rebasing the system using first-year cost-report data would violate the basic principles of prospective pricing. That system was intended to create positive incentives for hospitals to improve efficiency. The Medicare program would benefit--and has benefited--from a significant reduction in the rate of increase in expenditures. Hospitals would benefit by being freed from the constraints of the cost-reporting process to efficiently and effectively manage delivery of services. And beneficiaries would benefit both by the improvement in the financial health of the Medicare program and by the ability of hospitals to improve the services they offer. Rebasing effectively says to hospitals and physicians that their efforts to improve efficiency will earn, at best, only a temporary reward.

ADJUSTMENTS TO THE PROSPECTIVE PRICING SYSTEM

The second major category of issues addressed by ProPAC in its recommendations includes refinements in methods used to determine hospital payments. The ProPAC recommendations address several issues, including the treatment of rural hospitals, refinement of the adjustment for local wage variations, the definition and treatment of sole community providers, and payments for outlier cases.

Rural Hospital Recommendations

ProPAC has recommended that HHS complete the studies of the feasibility of eliminating or phasing out separate urban and rural DRG payment rates and the study of the treatment of sole community hospitals. AHA supports this recommendation. It is critical that the studies mandated by Congress be completed and all pertinent data released on a timely basis for public review and criticism.

The need for an ongoing and timely evaluation of the operation and impact of Medicare PPS is well illustrated by the problems facing rural hospitals. These include both the basic issue of adequate payment in the face of the often extreme conditions under which they operate and the more complex issue of competitive equity that is created by substantial disparities in payment to hospitals competing with one another in a local market. Nevertheless, the simplest solution to the problem, the outright elimination of the differential, would not be appropriate if it resulted in inadequate payments to urban hospitals.

work over the past year by a Special Committee of the AHA has focused on the special problems facing rural hospitals and has suggested that two actions are necessary. The first is an increase in the rural rate of payment to narrow the disparity in payment between urban and rural hospitals and to reflect changing patterns of utilization in rural hospitals. The second is a more intensive effort to develop better measures of case mix, both refinements of the DRG system and the development of measures of severity, that may allow the differential to be eliminated. These refinements should be developed for implementation in 1989, although development of adequate case mix measures will undoubtedly require an ongoing effort.

Area Wage Index Refinement

ProPAC recommends that the current area wage adjustment be modified by distinguishing between urbanized and non-urbanized portions of metropolitan statistical areas, and to distinguish between urbanized and non-urbanized rural counties. This recommendation is based on an analysis that reported differences in wages within labor markets as currently defined, specifically between urbanized and non-urbanized areas.

AHA has recently completed an examination of a similar proposal. This analysis was reviewed by all state hospital associations and most metropolitan hospital associations. The results of the analysis indicated that, although differences did appear to exist on average between urbanized and non-urbanized areas, those differences did not always appear to reflect the actual dynamics of individual labor markets. The conclusion that we drew from the analysis and subsequent review was that there are certainly problems with the current adjustment, but that the complete restructuring of the current adjustment would create at least as many problems and inequities as it would solve. A more effective and more appropriate approach would be to modify area wage boundaries on a case-by-case basis when a clear problem has been identified and documented. Rather than the ProPAC approach, AHA recommends that Congress direct HHS to adjust as appropriate the area wage adjustments through an exceptions process when hospitals can demonstrate that the current adjustment or labor market definitions do not reflect the actual operation of local labor markets.

AHA supports the ProPAC recommendation that the area wage adjustment be updated to reflect more recent wage data. Because the wage adjustment is intended to reflect relative differences in wage levels, it is important that it be based on current data. ProPAC also recommends that the wage adjustment be modified to better reflect variations in wages attributable to variations in occupational mix. AHA has examined this issue, and urges Congress and HHS to move cautiously in implementing such a change in the wage adjustment to avoid inadvertently and inappropriately increasing financial pressures on referral hospitals, unless better measures of case mix are developed. Because the current wage index is not adjusted for differences in skill mix, it partially corrects for differences in case mix between the hospitals located in different labor markets.

Sole Community Providers

ProPAC recommends that the number of hospitals designated as sole community providers (SCPs) be expanded. AHA concurs, in general, with this recommendation, and in addition urges Congress to simplify eligibility criteria for SCP designation. Specifically, AHA recommends that all rural hospitals that are the only hospital located in a county or located within a reasonable number of miles or travel time be designated SCPs. AHA also concurs with ProPAC's recommendation that the special treatment given SCPs be clarified. AHA has developed, however, a specific approach to be used to recognize the difficult operating environment of these hospitals. This approach should be considered as an alternative to existing SCPs. Specifically, the basic payment provided to sole community providers should be based on the amount that they would be paid if they were not classified as sole community providers; these hospitals should be paid a percentage of the difference between costs and PPS payments in instances where costs exceed PPS revenues. The percentage of the loss that would be reimbursed should be a

function of total volume, i.e., the smaller the hospital (as measured by total discharges), the larger the payment. Our analysis of this proposal indicates that it would cost very little but would provide significant help to exactly those hospitals most in need.

Outlier Study

AHA also concurs with the ProPAC recommendation that current methods of defining and paying for outlier patients be critically evaluated. The current outlier policy is particularly inadequate in small hospitals, but it is also a problem in hospitals admitting large numbers of extremely ill patients. The previous recommendation on sole community providers is one way of reducing problems created by outlier patients for small rural hospitals. For larger hospitals, particularly those serving as referral facilities, other methods of paying for outlier patients may be needed and should be studied.

Related Issues Not Addressed by ProPAC

In addition to the four issues that are addressed by the ProPAC recommendations, the Administration has proposed a number of changes that will affect the equity of PPS. These concern changes in the treatment of medical education costs (both direct and indirect), and changes in the periodic interim payment program. Although technically not part of PPS, these elements do contribute significantly to the overall impact of Medicare on the ability of hospitals to serve both Medicare patients and their communities.

Indirect Medical Education Payments. The Administration has proposed a reduction in the level of the indirect medical education factor. This proposal is based, in part, on more recent data and, apparently, on data from first-year cost reports. No change in the indirect medical education factor should be made at this time. The factor was originally included in PPS to compensate for the limitations of DRGs as a measure of case mix. Payments for indirect medical education costs are actually intended to reflect the differences in the types of services provided in teaching and non-teaching hospitals, not simply to reflect the effects of teaching on operating costs. Thus, changes in the formula that result in lower payments will require teaching hospitals to make substantive changes in the services they offer and the resources they employ.

Moreover, since the inception of PPS, the indirect medical education formula has been significantly altered, resulting in a substantial reduction in Medicare outlays and substantial reductions in payments to teaching and referral hospitals. A further reduction in the factor would be inappropriate for several reasons. First, the effects of this change have not been evaluated. The data presented by the Office of the Inspector General and CBO concern the relationship between payments and costs in the first year of PPS. In that year, 75 percent of the payments were based on a hospital's own costs in that year. Furthermore, the indirect medical education payments were based on the original formula, and not the reduced formula, until May 1, 1986--well into the third year of PPS.

Second, the implications for teaching and referral hospitals of moving to the 100 percent national rate have not been determined. The transition to national rates was expected to substantially change the distribution of revenues among hospitals. As noted above in the discussion of rebasing, the transition is expected to cause many hospitals that reported a positive margin in the first PPS year to slip into a loss position--even with the indirect medical education formula at its current level. Until the ability of hospitals receiving indirect medical education payments to continue operating as referral facilities under national rates has been verified, it would be inappropriate to demand greater reductions in costs from these facilities than from other hospitals.

Third, the adjustments intended to achieve greater equity between urban and rural hospitals recommended by ProPAC, and those supported by AHA, require urban hospitals to accept a smaller increase in prices than will be provided to rural hospitals. It would be inappropriate to further reduce payments to urban hospitals by limiting payments for medical education costs.

Direct Medical Education Payments. The Administration has also proposed a further reduction in payments for the direct costs of medical education. These reductions would be made before limits on medical education payments enacted in 1986 are fully implemented. Those limits would restrain the rate of increase in medical education costs in much the same manner as the system of cost-per-case limits enacted in the year prior to implementation of PPS limit the rate of increase in operating costs. Further restrictions on payment before the impact of those limits on medical education and patient care in teaching hospitals has been evaluated would be premature.

It would be particularly inappropriate to implement those provisions in the Administration's proposal eliminating reimbursement for costs of educating nurses and other allied health professionals. Recently, and despite the slower rate of increase in hospital employment, hospitals have again encountered a severe shortage of nursing personnel. Over the past several years, the demand for registered nurses has grown steadily. To limit the funding available to support education programs would compound the problems of recruiting sufficient numbers of qualified professional staff, both today and into the future. Before making further changes, Congress should consider the results of an HHS study, mandated by P.L.99-272 and due July 1, 1987, with respect to Medicare-approved educational activities related to nursing and other allied health professions.

Periodic Interim Payments and the Disproportionate-Share Adjustment. The Administration has proposed to eliminate the periodic interim payment (PIP) program for disproportionate-share providers. This recommendation is not based on any evidence that these providers would be able to finance the increased working capital that would be required by the delay in payment resulting from loss of PIP. The continuation of the PIP program for small rural and for disproportionate-share providers was based on a concern that these hospitals might experience substantial disruptions in operations if their cash flow was disrupted. Many disproportionate-share providers treat substantial numbers of the poor and experience significant levels of uncompensated care. The increased costs of financing working capital would be a significant burden for these facilities. Thus, the PIP program should be continued for all hospitals eligible under the law as currently written.

Congress also should preserve the disproportionate-share adjustment with the current formula and eligibility criteria.

Transitional Care. Finally, as discussed in the section on the annual update factor, one effect of the implementation of PPS has been to make both providers and beneficiaries aware of the growing need for sub- or post-acute care. Hospitals report growing difficulties in placing patients in nursing homes and/or with home health agencies. To ensure the availability of such services, Congress should amend Title XVIII to permit hospitals to provide all levels of care, not simply acute inpatient hospital care. By allowing hospitals to provide skilled nursing care to Medicare beneficiaries for limited periods of time, the quality and continuity of care would be increased at minimal cost to the Medicare program. Such an action would also contribute to the continued viability of rural hospitals, and help assure access to needed medical services to Medicare beneficiaries living in rural communities.

CAPITAL RECOMMENDATIONS

ProPAC has recommended that capital payments be folded into PPS over a total of 10 years. The ProPAC recommendation differs marginally from a similar recommendation in last year's report, and differs slightly from the current thinking of the Health Care Financing Administration. The key features of the ProPAC proposal:

- a three-year phase-in of capital payments for moveable equipment;
- a 10-year phase-in of capital payments for fixed equipment; and
- an overall limitation on the level of the capital add-on based on recently enacted limits on cost-based reimbursements of capital-related costs.

ProPAC has based this recommendation on its belief that cost-based payment intrinsically contains insufficient incentives to promote efficient use of capital, and further on its belief that distinguishing between fixed and moveable equipment reduces the problems posed by variations in hospital capital cycles. ProPAC also claims to have evaluated the vulnerability of hospitals under its incorporation approach and found that most hospitals will be able to make the transition from cost-based payment to payment as part of PPS.

AHA disagrees with the ProPAC position. There is no evidence that a continuation of cost-based payment will result in inefficient use of capital. If cost-based payment leads hospitals to disregard interest rates in making investment decisions, as ProPAC claims, then why have hospitals been so active in refinancing debt to secure lower interest rates? Refinancing has been common enough to prompt limitations on hospitals' ability to refinance--and lower capital costs for the Medicare program. Similarly, the ProPAC analysis of the incentives created by the cost pass-through assumes that capital and non-capital resources are substitutable and that the pass-through will lead to the substitution of capital for non-capital resources. Exactly how this substitution is to occur, given that the principal non-capital resource used by hospitals is labor, is not addressed by ProPAC. In fact, no evidence of substitution effects has been presented.

Capital expenditures are of several types. Many of these types have significant implications for operating costs. Many capital expenditures, particularly those that expand capacity or involve addition of services, result in new operating expenses, which must be paid for using revenues received under PPS. Limitations on operating revenues created by PPS create a strong incentive that discourages unnecessary capital spending, even though capital costs continue to be paid on the basis of reasonable costs. In addition, it should be noted that recent reductions in the cost-based payment formula create a strong disincentive to undertake marginal capital projects, particularly in the increasingly competitive medical care system.

ProPAC has failed not only to demonstrate the need to incorporate capital in PPS, but also to demonstrate that its incorporation method will not result in significant hardship. In the impact analysis, there was apparently little attention given to actual hospital capital costs. Instead, it was assumed--on the basis of a hypothetical analysis of representative hospital types--that any hospital with a high occupancy rate and a positive operating margin would be able to adapt to the new system. The ProPAC analysis excluded hospitals that would experience a shortfall of Medicare payments over costs on the operating side, and further appears to assume that the rebasing recommendation will not be implemented.

In effect, ProPAC has demonstrated that the average hospital facing average circumstances will be able to make the transition from cost-based to PPS-based capital payments. Unfortunately that is not the issue. The issue is whether non-average hospitals in atypical circumstances will be able to make the transition--and what to do about it if they cannot. Our analysis of approaches similar to those proposed by both ProPAC and the Administration indicates that incorporation will sharply increase the number of hospitals experiencing substantial shortfalls between their capital payments and capital requirements. Very little information is available describing the methods used by ProPAC in its analysis. The AHA analysis appears to differ from the ProPAC analysis in several ways. Most important, the ProPAC analysis is based on indirect measures of the impact of capital incorporation, as noted above, that were derived from a hypothetical analysis of the impact of the ProPAC proposal on model hospitals. The AHA analysis, in contrast, is based on a direct comparison of hospital capital costs to the amounts they would receive after capital is fully incorporated in PPS and at various points during the transition. This preliminary analysis indicates that even with the split transition for fixed and moveable equipment:

- nearly 30 percent of small hospitals (fewer than 1,000 admissions annually) and more than 30 percent of large hospitals (8,000 or more admissions annually) would experience a capital shortfall of 10 percent or more;

- nearly 20 percent of small hospitals (fewer than 1,000 admissions annually) and more than 15 percent of large hospitals (8,000 or more admissions annually) would experience a shortfall of 30 percent or more;

- approximately 40 percent of mid-sized hospitals would experience losses of 10 percent or more, and approximately 30 percent of these hospitals would experience losses of 20 percent or more;

- nearly one-fourth of all rural hospitals and almost 35 percent of all urban hospitals would experience a loss of 20 percent or more; and

- more than one-fifth of all non-teaching and more than one-fourth of all teaching hospitals would experience a shortfall of 30 percent or more.

ProPAC apparently recognizes the problem, because an appeals or exceptions mechanism is provided in recommendation 11. ProPAC further recognizes that a number of hospitals may have problems adapting to the new system because it calls for strict criteria to limit the number of hospitals that would actually receive a capital payment adjustment.

AHA has devoted and will continue to devote significant resources to development of a fair and adequate method of paying for capital by the Medicare program. However, on the basis of all currently available information, AHA has concluded that the only method of paying for capital that provides reasonable assurances of adequacy and equity is a continuation of the cost past-through. This position has the broad support of the hospital field and reflects a strong consensus among hospitals in all parts of the nation that none of the methods of paying for capital that has been proposed would result in either adequate or equitable payment.

AHA has attempted to evaluate comprehensively the impact of ProPAC's and the Administration's proposals on hospitals but lacks the information needed to perform the definitive evaluation. The data presented above, based on the information available, do strongly suggest that until the data needed for a more thorough evaluation are available, no change in capital payment policies should be enacted.

Therefore, AHA recommends that any action to incorporate capital into PPS be delayed until at least October 1, 1989, to provide additional time for development, evaluation, and refinement of an adequate and equitable method of paying for capital-related costs.

DRG REFINEMENT AND CASE MIX MEASUREMENT

In this year's recommendations, ProPAC has again called attention to the need for ongoing efforts to improve the measurement of case mix. Specifically, the ProPAC recommendations include the creation of several new DRGs, modifications in the way in which the DRG system treats patient age and other factors, and a call for examination of the fit between the DRG system and ICD-9-CM coding guidelines. In addition, the recommendations again include a proposal to make supplemental payments for inpatients receiving nuclear magnetic resonance imaging, and call for a "reabstracting" study to determine the extent to which reported changes in case mix are the result of more accurate coding or of actual changes in the mix of patients admitted to hospitals. More broadly, this year's recommendations again call for identification of new data, presumably including data on severity of illness, that could be used to develop a more accurate system of DRGs.

AHA generally supports the recommendations on DRG refinement and case mix measurement. The development of valid, reliable, and accurate measures of case mix is essential to the longer-term success of PPS. It is unfortunate that so little attention has been given to validation and refinement of the current DRG system in the four years since enactment of PPS amendments. The ProPAC recommendations are a significant step in the right direction, though not one with which AHA is in complete agreement.

New DRGs

AHA supports ProPAC recommendations to create several new DRGs for patients receiving newly developed technologies, specifically the implantable defibrillator and cochlear implant. Both of these technologies represent major breakthroughs and neither appears to fit into any existing DRG.

DRG GROUPER Modifications

ProPAC has recommended several modifications in the DRG GROUPER, the computer algorithm that assigns DRGs based on patient characteristics. It is impossible to evaluate the appropriateness of specific modifications until the data used in arriving at the recommendations are available for public review and comment. However, AHA can agree with the recommendations that call for regular review of the use of complications and comorbidities in assigning DRGs and the structure of the surgical procedure hierarchy. No specific modifications in either of these areas are proposed, however.

AHA is more concerned that the proposal to alter the use of patient age in assigning DRGs is premature. ProPAC has recommended that patient age no longer be used as a proxy for complications and comorbidities. The apparent justification for the recommendations is that there appears to be a greater difference in costs between patients with and without complications than between Medicare patients who are over and under 70 years of age.

The ProPAC recommendation does not adequately reflect either the complicated relationship between patient age and cost of treatment, nor has ProPAC taken into consideration in developing its recommendation the fact that the DRG system is used by organizations other than Medicare. To avoid unanticipated or unintended effects, AHA recommends that the ProPAC recommendation be modified as discussed below. This modification is intended to address two issues.

First, a difference based on age does appear to exist, at least in some DRGs. Analysis by AHA has suggested that the picture is somewhat more complicated than might be assumed from the ProPAC recommendation. In some DRGs, older patients have substantially higher costs, while in other DRGs exactly the opposite is true. When a difference in costs is found, different DRGs should be established.

Second, Medicare is not the only user of the DRG system. The ProPAC recommendation is based on an analysis of Medicare patients only. The ProPAC analysis did not, apparently, consider whether differences based on age exist when comparing Medicare and much younger patients. The recommendations of ProPAC on this issue should consider the implications of changes in the DRG system for all users of the system, not just use of the system by Medicare. The result of creating a "Medicare DRG" system would be proliferation of DRG systems, each designed to meet the needs of an individual user. Such a situation should be avoided, not only because of the cost of maintaining multiple DRG GROUPERs, but also because of the confusion such a proliferation of systems would create.

These problems notwithstanding, ProPAC has identified an important defect in the design of current DRGs. Consequently, AHA recommends that the ProPAC recommendation be adopted, but in a modified form. Specifically, DRGs that involve distinctions based on either a patient's age or the presence of complications and comorbidities should be restructured as follows:

- patients with neither complications nor comorbidities and younger than age 70;
- patients with neither complications nor comorbidities and age 70 or greater;
- patients with complications or comorbidities regardless of age;

AHA recommends that work continue to determine the appropriate methods of reflecting the independent relationship between age and cost of treatment, after controlling for complications or comorbidities on a DRG-by-DRG basis.

Payment for MRI Services

ProPAC has again this year recommended that a separate payment for nuclear magnetic resonance imaging (MRI) services be established. The rationale for this recommendation is that because a small percentage of patients in any DRG actually receive the service, the price for the DRG does not adequately reflect the costs that would be incurred by a hospital with a significant number of patients needing the service. In effect, the patients needing the service are not average, but the DRG system is designed to provide only average payments. A separate payment is one way of getting around the problem of averages.

AHA supports the recommendation of ProPAC, and notes that similar logic should also be applied to other expensive services that are needed relatively infrequently by patients in a DRG.

ICD Coding and Reabstracting Studies

AHA supports the ProPAC recommendation that greater attention be given to improving the fit between guidelines for classifying patients by ICD-9-CM code and the structure of the DRG grouper. However, in developing specific recommendations on this topic, great care should be taken to preserve the integrity of the ICD system. It would be inappropriate to change the ICD system to compensate for problems with the DRG system. Instead, the DRG system should be modified to better reflect coding conventions.

Finally, AHA is pleased ProPAC has concluded that reabstracting studies are the only appropriate method of determining the extent to which reported changes in case mix are due to more accurate coding or to real changes in case mix. Several years ago when this issue first arose, AHA urged HHS to conduct such a study, but HHS elected to use a more indirect method of evaluating changes in case mix that could not definitively resolve the issue. Consequently, AHA urges the Administration to implement the ProPAC recommendation, keeping in mind two caveats.

First, coding requires considerable judgment. In reviewing coding, a mechanism for validating the decisions of the reabstractor must be provided. Second, a reabstracting study must focus on changes in accuracy of coding. Its purpose is not to detect inappropriate coding or "DRG creep." Peer review organizations (PROs) are responsible for DRG validation and ensuring the integrity of coding. The reabstracting study must focus only on the issue of whether a given patient's diagnosis and surgical treatment would have been coded in the same way in a previous period.

BENEFICIARY PROVISIONS

AHA supports ProPAC recommendations calling for changes in the level of inpatient hospital cost-sharing and evaluation of PRO quality of care review activities. However, AHA believes that evaluation of the impact of the PRO program on quality of care should be conducted by an organization independent of HHS or at a minimum under the direction of an independent body.

Cost-Sharing

The cost-sharing requirements currently in place were designed with the incentives of cost-based reimbursement in mind. As length of stay has fallen, the level of copayment has risen sharply. It would be entirely appropriate to reduce the level of required copayment to its pre-PPS level. It would not, however, be appropriate to finance the reduction in cost-sharing by arbitrarily limiting hospital payment. Instead, a portion of the considerable savings already achieved by PPS and the reduction in the number of inpatient admissions that has occurred since 1983 should be used to reduce beneficiary out-of-pocket expenses.

It would also be appropriate to eliminate the spell of illness concept and limitations on coverage of inpatient treatment. Both of these issues have been addressed in statements submitted to this committee on catastrophic illness.

Quality of Care Studies

Since the inception of the PRO program, AHA has attempted to work with both Congress and the Administration to ensure that beneficiaries continue to have access to high quality medical care. AHA believes that PPS has been implemented without adversely affecting the quality of care provided by hospitals. PPS has also called attention to the need for a better system of post- or sub-acute care. Of particular concern is the extent to which policies adopted by PROs or fiscal intermediaries result in denial of access to either inpatient or needed post-acute care services.

Another area of concern is the adequacy of criteria used by PROs in making both appropriateness and quality determinations. Determinations that care is unnecessary are often overturned upon reconsideration. Much greater attention must be given to development of sound criteria and methods for making such determinations. Furthermore, because hospitals are not permitted to seek either administrative or judicial review of PRO decisions, an important check on unreasonable decisionmaking by a PRO or by HHS is missing. Consequently, AHA recommends that the type of study recommended by ProPAC be undertaken but that it be directed by an independent body.

CONCLUSION

ProPAC's annual report consistently demonstrates the importance of independent oversight of Medicare PPS. In its recommendations, the Commission has identified many significant issues and developed proposals for addressing several of them. There will be no shortage of work for ProPAC over the coming year.

AHA is generally supportive of the Commission's recommendations concerning improvements in the DRG system, treatment of rural hospitals, and beneficiary cost-sharing. AHA is opposed, however, to proposed rebasing of PPS, and to the proposed incorporation of capital into the system. AHA's opposition to rebasing is a matter both of principle and practical consideration. Rebasing would be a fundamental departure from the original design of the system, which stressed creation of positive incentives to improve efficiency through establishment of a reasonable annual update factor. At a less philosophic level, the proposed rebasing is based on first-year cost-report data, which AHA believes on the basis of available data significantly overstate the magnitude of the difference between what Medicare paid for inpatient services and what it cost hospitals to provide those services. Moreover, the growing shortfall between the rate of increase in prices and inflation since the first year of PPS has effectively eliminated any margin that hospitals may have earned in that first year.

AHA's opposition to incorporation of capital follows an extensive effort to evaluate all of the capital proposals, and is based on the fact that of the proposed methods of paying for capital that have been identified to date--including the ProPAC proposal--only a continuation of the cost pass-through will provide assurances of both adequate and equitable payment at the present time.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman. Dr. McCarthy, could you comment, please, on this cash flow issue which we were discussing earlier, as it relates to the PIP program and to the slowdown, or proposed slowdown in payments for electronically submitted bills.

What does this mean to individual institutions? Are any particular groups hit harder than others? What is your position on it?

Ms. MCCARTHY. I can get for you figures on those facilities who might be hit harder than others, but let me first share with you a data problem we are having.

We have the list of the disproportionate share hospitals. We do not have from HCFA, although we have asked for that, the list of the disproportionate share hospitals, that are the PIP hospitals, what payments they are currently receiving now, and we have asked.

So that I cannot do what I would like to do. We have made that request earlier, I wanted to have that information for you, and I cannot give that to you.

The best that we can do is say this: the reason of course for putting those facilities on PIP was the issue of their cash flow, their prompt payment. They are the hospitals that traditionally have suffered most in this area. The removal of PIP makes a significant difference. The intent that you had was certainly not to slow down the process of paying for bills, even with PIP eliminated, and therefore I can only say we can do the best that we can on getting data on all hospitals on a list, but we are, until we get that list from HCFA, just as handbound as you.

Mr. GRADISON. Thank you. I would like to inquire about an article which appeared in Sunday's "New York Times" and ask whether it correctly reported your saying that hospitals need to earn a surplus on Medicare payments so they can build up reserves and guard against unpredictable swings in revenue from other sources?

Ms. MCCARTHY. I had not read it.

Mr. GRADISON. Is that your view?

Ms. MCCARTHY. Hospitals need to have more than payment for their costs, to be able to guard against even fluctuations in the type of Medicare patient that comes into their facility.

You cannot operate on just receiving costs, and stay there to provide service the next day. I truly believe hospitals need, if you will, a surplus margin, and it should be from all payers.

I do not think any one payer should subsidize another payer. But that particular quote sounds to me as if somebody just got half of it right.

Mr. GRADISON. Your full statement which you just made certainly clarifies it in my mind. Thank you very much for appearing. Thank you, Mr. Chairman.

Chairman STARK. Thank you. Would the American Hospital Association support creation of a better data base or a uniform system of accounts? I am not sure that would be the better database, but would you support our efforts in that?

Ms. MCCARTHY. We would certainly support working with all parties to identify the data elements that will provide the information we need to work within the Prospective Payment System.

Chairman STARK. And the information we need as well?

Ms. MCCARTHY. Yes, of course. There is a big difference between that and the SHUR manuals of the late 1970's where——

Chairman STARK. Well, suppose it came out, that what we would all need—to give you what you need, and what we need, and what HCFA needs?

Ms. MCCARTHY. I would hope not, because when we——

Chairman STARK. Well, hypothetically, let's say that we now use a uniform billing—and I gather there is no objection to that.

Ms. MCCARTHY. The issue with the SHUR manual was twofold. One, it is uniform accounting, and the question that was raised was the needs the facility had for even management purposes, and whether the uniform accounting that was being mandated would meet the facilities needs, and after significant testing was found it would not, so we would have to run two sets of accounting.

The cost of implementing the program was phenomenal. We are now moving toward a price-based system. To take a giant step back and say, let's get into that type of detailed, costly cost reporting, I think is problematic. Perhaps my response is colored somewhat, but I believe we collect an awful lot of data that we do not need.

Chairman STARK. Doctor, what data would you suggest that we use, then, if we ran an exceptions process?

Ms. MCCARTHY. I would be pleased, truly, to sit down on——

Chairman STARK. Wait a minute. If you do not want to do the cost reporting, how are we supposed to have an exceptions process, for example? You just recommended we do that. We have got to use real data for that. Where are we going to get it?

Ms. MCCARTHY. If we are talking about an exceptions process on labor charges, then I think it is quite fair to ask the facility to come in with the information that will show you, clearly, that their labor costs far exceed what they are being paid for their labor expenses. I have no problem with that.

Chairman STARK. Then why should we not then use real data for rebasing?

Ms. MCCARTHY. The difference between an exceptions issue and putting in place a large, very costly system, cost-based——

Chairman STARK. No, no. For the current rebasing that we are talking about, why shouldn't we use real data for that?

Ms. MCCARTHY. We have information available on margins, right now, and the hospital financial reports are on file right now, that show that that margin data and the Medicare cost reports are overstatements.

Now that gets back to my point. What information——

Chairman STARK. Who made the overstatements, the hospitals, or HCFA?

Ms. MCCARTHY. No, I think it is a function, in part, of the cost report. Part of that overstatement is due to a heavier allocation of overhead than should have been made, and that is a technical issue in the way the cost report is set up.

I think the second reason that the cost reports may be as bad as they are has to do with the assumption that a day of care to a Medicare patient is the same as a day of care to a non-Medicare patient in the resources consumed, and the information we have show that

our Medicare patients tend to have more comorbidities and illnesses.

Chairman STARK. What kind of information is that which you have, that I do not? Numbers?

Ms. MCCARTHY. No, you have the same numbers we have. It is a matter of just looking at those numbers.

Chairman STARK. I see. Okay.

Ms. MCCARTHY. But again, we will provide those for you. You have those numbers.

Chairman STARK. If you feel that PPS is a pricing system—and I gather you like the PPS system and feel we should get on with it—then does it not follow that the less-efficient hospitals will not be able to provide the product at the price set? By definition, if you have a price system there will be some of your members who cannot have a surplus at that price, is that not correct?

Ms. MCCARTHY. Yes. There are two comments I would make. The first is that the American Hospital Association supports the DRG system with some needed changes, not the least of which is some important changes for patient intensity.

It is by no means a perfect system.

Chairman STARK. But do you envision, under any circumstances, a DRG system that would provide all hospitals a 100 percent of their cost plus some reserves?

Ms. MCCARTHY. No, it is not possible.

Chairman STARK. That is not possible, is it?

Ms. MCCARTHY. It is not possible.

Chairman STARK. All right. Now, given an average occupancy of 60 percent, it also makes some sense that perhaps we ought to reduce the number of hospitals. Doesn't that make sense to you?

Ms. MCCARTHY. We have reduced the number of hospitals in operation. They continue to close, to merge. The big challenge that we have is being sure that hospitals that you do not wish to close do not close, but——

Chairman STARK. All right. How do you do that under a price system, Doctor?

Ms. MCCARTHY. You at least provide an exceptions process, when you are dealing with a gross formula, that is not necessarily tied to efficiency or inefficiency. It is tied to a number of factors. You provide an exceptions process so that you can hear whether in fact this facility is being unfairly treated, not because it is inefficient—it is not being paid inappropriately because it is inefficient. It is being paid inappropriately because of the system.

And what we wish to avoid is, you do not want to put a needed hospital——

Chairman STARK. Define inappropriate. Not enough, isn't that what you mean by inappropriate?

Ms. MCCARTHY. No, no.

Chairman STARK. Wait a minute. If you have got a price system——

Ms. MCCARTHY. The changes, for example, in the rural hospitals right now, where there are massive changes in utilization, right?, and the changes in what it costs them——

Chairman STARK. All right. Let's take all rural hospitals. Even under a price system, some rural hospitals are going to go broke, and some will not. Isn't that true?

Ms. MCCARTHY. That is true, but——

Chairman STARK. And is there anything wrong with that?

Ms. MCCARTHY. I am not here, either, to say that what you need to do is devise a system that keeps every facility that is in place today in place tomorrow.

What I am suggesting is that the system that we have needs changing because it is not an equitable payment system. There are in fact within the system some serious flaws in recognizing——

Chairman STARK. Will there ever be an equitable price for——

Ms. MCCARTHY. We ought to work toward it. We ought to work toward it. We are talking about a system that people's lives and functioning are involved in, and it is important for you to keep it in place.

Chairman STARK. Doctor, let's leave quality out of this a minute. We are talking price now. This is not the A&P. Now, I happen to like the DRG system, but I am just suggesting to you that you cannot have it both ways. You cannot have a DRG system that says, look, for whatever they call that thing, a gall bladder removal, there is a price. We will adjust it here and there, but if you cannot make it, and you have got a hospital that does all gall bladder operations and they cannot live with the price, then we have to say, tough, let them close.

Ms. MCCARTHY. But first you want to be sure that you have set the price correctly. That is the first responsibility we have. We do not have a responsibility to say pick a number, any number, and if you cannot live within it, we do not care what happens. You want to set the price fairly.

Chairman STARK. I doubt that there is any DRG payment and I am just making a guess that I could not find several hospitals in the country charging that same price to other people, other than Medicare. Possibly even lower. So I mean——

Ms. MCCARTHY. Or possibly higher as well.

Chairman STARK. Would you challenge that?

Ms. MCCARTHY. Or possibly higher as well.

Chairman STARK. Wait a minute. Let me ask you. I do not know, pick a DRG rate for any——

Ms. MCCARTHY. Is it possible——

Chairman STARK. Wait, Doctor, may I finish my question?

Ms. MCCARTHY. Sure.

Chairman STARK. Can somebody give me a DRG. A simple appendectomy—I do not know what it costs—but whatever the DRG payment is, are you suggesting that I could not find any hospital that would, in this country—or how many would you think are offering that same procedure for the same price?

Ms. MCCARTHY. Until I would look, I really would not have any idea.

Chairman STARK. Would you guess that there are at least $2,000 or $3,000?

Ms. MCCARTHY. I am pulling a number out of the air, and I am generally opposed to pulling numbers out of the air, so I have no idea.

Chairman STARK. Let me put it this way: has there been any evidence that there are any DRG payments that no hospital would charge——

Ms. MCCARTHY. The DRGs, by definition, Mr. Chairman, are average payments. There are those that are above and those that are below.

Chairman STARK. And there always will be, won't there?

Ms. MCCARTHY. But the extent to which the variability of the cases that fit within a DRG are adequately affected, or reflected in the price, is very important, and so part of what we need to do is adjust the payments, or adjust the variability, get to a point where the price is a fair price——

Chairman STARK. But are you saying we should have 6,000 different prices, one for each hospital?

Ms. MCCARTHY. Many——

Chairman STARK. Wait a minute. I mean, how far——

Ms. MCCARTHY. Many years ago, at this point, the AHA suggested an approach to Congress, and that was a blended rate approach, because that blended rate approach would have looked to the peculiar cost base.

But it also would have permitted payment at a national rate immediately for cases where there was tight variation around the mean. All right. I know you do not like it now, you did not like it then, but it would have taken care of a number of the difficulties with the system.

Chairman STARK. That is the old system. I keep hearing from you, and HCFA, we want to get the price. I understand the price system. So do you. I buy cars. I shop around to get the best price, and I really do not give a hoot whether the dealer goes broke. I rather suspect I am the one who is going to go broke paying for the car, not the dealer selling it to me, but that is the price system.

And the price system anticipates that there will be some people who make more, and some people who make less, and you are wholeheartedly endorsing the price system, in your testimony.

But then you are saying, but we have got to have a price system plus something else, and I do not know what that something else is.

Mr. GRADISON. Would the chairman yield.

Chairman STARK. Sure. I would be glad to yield.

Mr. GRADISON. I would suggest we do not have a price system, that the DRGs are a price-fixing system, but they are not a market-derived price system.

And that if we did have one, we probably would have a case in which some of your members would not get any Medicare business at all. They would have nothing to come in and ask for exceptions on because they did not get the business that year.

Or the price system might be one in which we took bids at a given community, accepted the low bid, and then said that any other institutions which wanted to care for—that may have been higher bidders, but that want to do business that year will have to meet the lowest bid in order to qualify. So that the business could be spread around but the low bidder would set the price.

Now, I mean, this question of fair price, or fair profits, gosh, that is an issue for Jesuit theologians, and they have not had much suc-

cess in getting something that people could agree on over several hundred years.

I am really troubled by where we are going here because I think we have got to patch up the DRG system. I think it does not make any theoretical sense, but of course, as we have been reminded as recently as this weekend, much of this has been put together by economists, and economists spend their lives trying to prove that something that works in practice will not work in theory, and I think it is worth trying to make this thing work.

But I think ultimately it will probably break down, and then we have got to decide at that point, do we go to a really regulated—I mean—price system, or true regulated price? Or do we go to a market-developed price where you take bids for a couple years, which, by the way, in my communities that is what the Blues are doing.

They have said they want to take bids, and they take bids, and some hospitals are not getting any Blue Cross——

Ms. McCarthy. Again we will be back to the point where we need to set that capitated rate at a rate that is fair, if you want the care delivered in the appropriate way.

Maybe you do not care so much if the car you buy does not work, but you sure care if the health care you bought is not appropriate.

I am not asking for a price plus something. What we are trying to suggest here is that the DRG payment system needs to be adjusted to reflect—it is all budget-neutral now—but it needs to be adjusted to reflect where the formula falls unevenly, and inappropriately, and not because the facility is inefficient. Now that is not asking for plus——

Chairman Stark. That is not a problem, but what you are asking for—and Mr. Gradison comes right on point—you are going in a couple of directions at once, and you have got to choose.

Sooner or later, the American Hospital Association is going to have to pick. We are basically still combining some historic cost payments with and some prospective payment, and we are going to national rates whether we like it or not. That is the law. I did not happen to write it.

You are suggesting that we take into account a variety of things which require extensive data-gathering. Now we can go the direction of detailed data-gathering in fixed prices which we will administer—that means the Federal Government. If we are giving the hospitals 60 percent of the business, we are going to get into a managed hospital operation through a Federal price system, and go in that direction. That is one direction.

The other direction is what Mr. Gradison suggested. These are pure bids with no adjustments, except that we will go into the community, and then each one of your hospitals are going to have to bid.

Those are two competing and diametrically opposed routes, and they are the only options, it seems to me, open to us.

Now we can proceed in one direction or the other. Sooner or later, the hospitals are going to have to decide which way——

Ms. McCarthy. We really are not looking to have it both ways. Let me state clearly, for the record, that the AHA is more than willing to work with you, Mr. Chairman, and with members of this

committee, on the identification of the data that would in fact remove some of the smoke from what is necessary as adjustments and updates in a DRG system.

Let me just state it clearly, we are willing——

Chairman STARK. Would you object to our bidding for DRGs in a community?

Ms. MCCARTHY. I do not see the big difference you see between a DRG price and a per-case price that is set by government. To me they are both price setting.

Chairman STARK. Right.

Ms. MCCARTHY. They are not a competitive market. One is an all-inclusive rate; one is a smaller rate.

Chairman STARK. What if we did go to it?

Ms. MCCARTHY. Then the question really becomes do you want to contract with only certain providers and not other providers. That is an issue that you are going to need to move——

Chairman STARK. We could contract with all. We just set the price by the bidder. In other words, there would be some hospitals that will bid a price that ostensibly would lead them to a 100-percent occupancy. So they would set their price with a marginal increase in volume, or the marginal benefits of the increase in volume and they would establish their price. If other hospitals chose to meet it, in Mr. Gradison's suggestion they would be able to take patients at that price.

But the pricing mechanism would be a true competitive bid in an area. That is one direction we could go.

Ms. MCCARTHY. We are moving in that direction cautiously in the Medicare program now with the introduction of more and more beneficiaries into CMPs and HMOs.

Chairman STARK. My question is, what does the American Hospital Association want to do? Would they prefer that kind of bidding?

Ms. MCCARTHY. What we would like you to do is take a good long look at how you set that price. Mr. Chairman, again, they are the same type of thing. One is a system where it is an all-inclusive price; one is a system where it is a DRG price. In both instances, you had better be pretty correct when you come up with the price.

Chairman STARK. What if I do not come up with the price? What I am asking you is would you prefer——

Ms. MCCARTHY. You have got to put something out there for bid.

Mr. MOODY. Would the chairman yield?

Chairman STARK. In a moment. If we have an alternative in setting the price, we could go and take bids, as was indicated before. That is one way to get a price. We could take the lower bidder, and that would be our price in metropolitan New York City.

The alternative is for us, through reviewing costs and a whole bunch of gyrations, to set a price. Those are the two procedures we could follow.

Which of those two procedures would the American Hospital Association prefer?

Ms. MCCARTHY. All I can say in response, to be as responsive as possible, is to say that we are looking at, right now, alternatives to a DRG system.

Chairman STARK. Yes, but you do not have the alternative. That is not your luxury. It is our decision. I am asking which you prefer.

Ms. MCCARTHY. But we might be able to come to you and say, look, we have looked at this and this is something you ought to seriously consider. You are asking me now do I think it is a good idea, and I am saying we are trying to evaluate those types of things.

Chairman STARK. Which do you prefer?

Ms. MCCARTHY. Again, I am not going to give you an answer like this and say go do it until we have finished evaluating it.

Chairman STARK. Okay. That is an answer. Then what you are forcing us to proceed and make that decision without your answer. That is okay.

Ms. MCCARTHY. No. Today I cannot give you an answer I do not have today. What I have tried to share with you is that we are currently, and have been for 8 months, looking at alternative payment systems to see how I could respond to the direct question you asked. I cannot respond to it today. That does not mean I do not intend to be able to respond to it.

But to ask me to just answer you before that work is done is for me to give you an answer that is not worth your having heard it.

Chairman STARK. Okay.

Mr. Moody.

Mr. MOODY. Thank you, Mr. Chairman. I want to jump in, but do you have any other questions?

[No response.]

Mr. MOODY. Okay. Just thinking out loud, looking at a bidding system, what would be wrong with doing precisely that, where we would not set the price, we would simply contact all the providers in the New York metropolitan region or the San Francisco metropolitan region and ask for their bids? That would have the property of aliowing each one of them to come in with a bid, and that would be the price Medicare would pay, and patients would be free to use that facility with that bid and be sure that they would come right in on target. The beauty of that would be that it would be cost-based, particularly fashioned to the cost of that region and that particular provider hospital that would be offering it. Instead of us sitting here and trying to figure out what is cost-based and what is not cost-based and instead of us sitting here and trying to shape payment systems and set prices, we would not be setting them at all. We would be responding precisely to the real live cost situation that is out there by saying, What is your bid? What is your bid on the appendectomy and the following 89——

Ms. MCCARTHY. You would have a set of different prices because you would have a set of different bids. I mean, I am assuming that you are not going to take a bid from a single provider. If you are in an area, you will take whatever bids are acceptable, so you would have a set of different prices.

Chairman STARK. No, no. We would take only the lowest price.

Mr. MOODY. Right. It is like when the government——

Ms. MCCARTHY. Then we simply would need to take a look at, one, whether that price was low and you were comfortable with what you were buying for the price, because you are not only paying price here. Quality we have to look at.

Second, even if that were true—and that is fine—we need to look at what is the patient load in that particular area, and can the fa-

cility that is giving you the price and that you have opted for take care all of the patients in that area.

The third thing you want to look at is what are the services that that facility offers? Do they have all that we need? Or where else need you buy to substitute?

There are a number of questions that you want to evaluate before you say this is an intelligent and healthy way for us to go as the federal government with responsibility for the Medicare beneficiary. Those are some of the issues that we are looking at.

Chairman STARK. Well, then, those issues—I am sorry.

Mr. MOODY. No, go ahead, Mr. Chairman.

Chairman STARK. Those issues, then, say that you cannot have the price system that you suggest that you are supporting. I mean, you are just saying that prospective payment will not work and that price bidding will not work.

Mr. MOODY. Let me try to react to what you have just said. You know, when the Government decides to buy an automobile, it checks bids—Plymouth, Ford, and Chevy and the rest—and it picks the low bidder. Obviously, it has to meet quality constraints that are assumed. We assume the Big Three can produce quality cars, and we assume the highly professional organizations calling themselves hospitals in the New York metropolitan region, or in my region, are able to provide quality for each of the procedures they are bidding. We would not assume that they are not—let me just finish.

Ms. MCCARTHY. No, I am just saying there are issues to look at. Look at the difference between health care and the automobile.

After we are sure that the hospital that you selected has the services that all Medicare beneficiaries need——

Mr. MOODY. Wait a minute.

Ms. MCCARTHY [continuing]. Can care for all the beneficiaries, because you have only accepted one bid, that the physicians that the beneficiaries use have privileges in that hospital, and that you are, therefore, not putting restrictions on freedom of care.

Mr. MOODY. Wait a minute. I do not think you understand the system I am proposing.

Ms. MCCARTHY. I am sorry.

Mr. MOODY. You are raising a lot of issues, which is fine, but you raise so many, you raise them six or seven in a row, I cannot jump in. It is a little hard to react.

I am saying you have asked all the hospitals in metropolitan New York: What is your bid for appendectomy?

Ms. MCCARTHY. From each hospital?

Mr. MOODY. You give them all a chance to bid. Some may not want to. Then you ask all the hospitals in the metropolitan region: What is your bid on tonsillectomy? Okay. Now, it may not be the same hospitals that come in with a tonsillectomy bid.

Then you go through the whole list. That sets a price schedule for that whole list.

Ms. MCCARTHY. But then you are asking the hospital, if I understand now——

Mr. MOODY. Not the hospital; you are asking all hospitals in New York.

Ms. MCCARTHY. But you only accepted one price.

Mr. MOODY. No. We accept one price. Any hospital is free to meet that price.

Ms. MCCARTHY. But then you have not done what I think the chairman was suggesting.

Chairman STARK. Well, there is a variety. That is the same thing.

Ms. MCCARTHY. But now I have a hospital in Metropolitan New York who did not get the bid for the appendectomy.

Chairman STARK. Right.

Ms. MCCARTHY. All right? And let us say that now all hospitals have to accept——

Mr. MOODY. Wait, you are not listening.

Ms. MCCARTHY. I am trying to listen.

Mr. MOODY. Here is the question. If Hospital A gets the low bid on appendectomies, Hospitals B, C, D, through F would also be able to have the option of coming in and doing the appendectomy at that price. We are not saying that is the only hospital that can do it.

Ms. MCCARTHY. But suppose they could not do it at that price? They would have submitted that price to you to begin with.

Mr. MOODY. Not necessarily.

Chairman STARK. Suppose they cannot do it at the DRG price today? What do you do?

Ms. MCCARTHY. Well, this is a question that we are facing. How do we be sure that the price that the Medicare program is willing to pay is going to cover the care that the beneficiary needs?

Chairman STARK. You are right, and you cannot.

Mr. MOODY. It is incredible.

Chairman STARK. Doctor, you cannot. That is the simple answer. You cannot, and if you want a price system, you cannot have a system that will pay the price that the lowest, the least efficient producer needs.

Ms. MCCARTHY. But, Mr. Chairman, I do not think you want to go where this line of questioning is going either. Let me, if I can, just to be sure I recap and understand this.

You are suggesting that in an area you would take bids on a procedure, and you would buy the lowest bid. And it came in from one hospital, and there are 15 hospitals bidding. And you would say to the other 14, "If you want to do this procedure, you do it at this price."

Chairman STARK. Yes. And you know what you are suggesting, Doctor? Just the opposite. You are saying I should go into an area and take bids from the hospitals and take that price, the highest price from the least efficient producer, so nobody goes broke in the area.

Ms. MCCARTHY. I never said that, Mr. Chairman.

Chairman STARK. That is the effect.

Ms. MCCARTHY. No, I never said that.

Mr. MOODY. No, but that is the effect of some of the alternative systems.

Ms. MCCARTHY. It is not the effect of the American Hospital Association's recommendations to this committee and never has been.

Mr. MOODY. Let me go back to what I am asking. You correct me now. I seem to understand that you would go procedure by proce-

dure, bid it throughout the region and see what came up. Hospitals would give you their price. Some hospitals would have the same price; some hospitals who are less efficient have a higher price.

Any hospital would be free to readjust. They might go back and say, look, let us see if we can meet that price, just like an automobile dealer might say. Look, we lost a contract on Plymouth. We lost the contract to the government. Let us see if we can get our costs down and meet the contract next time. If the government said we have an open order to purchase any Plymouth or any Ford at that price, so be it.

It would then begin to put pressure on the hospitals to be efficient and begin to meet those prices, those that were less efficient. The most efficient hospital would provide the commercial yardstick.

Now, you have to look at in a dynamic context.

Ms. MCCARTHY. May I add just one thing there?

Mr. MOODY. No, let me finish. Then I will turn it over to you.

Ms. MCCARTHY. All right. Certainly.

Mr. MOODY. In a dynamic context, yes, only one out of 14 hospitals might be prepared to meet that price at that time. However, within a period of adjustment, where they can alter their cost structures—and nobody would pretend the people cannot rearrange cost structures to bring them down in private or non-profit sectors—then other hospitals would begin, maybe two and three and four would begin to meet that price. And you would do that across the whole DRG spectrum.

What would be wrong with that? Why would that not be precisely the sort of market competitive forces, but without government setting prices geared frequently to less than fully efficient institutions, which we now have?

Ms. MCCARTHY. Listening now to your proposal, I can only give you two thoughts. The first one is that if only one hospital could produce it at that price——

Mr. MOODY. At that moment.

Ms. MCCARTHY. We would have an access issue.

Mr. MOODY. Perhaps. Perhaps. We do not know.

Ms. MCCARTHY. But there is a real potential for an access issue, particularly if you had 15 hospitals in the area and only one could meet it. A potential, and that is not good for the Medicare program.

But the second one is there is an assumption that you are making, and that assumption is that, in fact, all hospitals have the same kinds of cost structures, and the only reason that they are not coming in for that $1,000 is that they are inefficient.

Mr. MOODY. No, that is not an assumption. There may be multiple reasons. One of them may be inefficiency, or less than full efficiency.

Ms. MCCARTHY. But you might have the most highly efficient facility that, because of the scope of the services, the offered procedures, the standby technologies, could never come down on that price.

Mr. MOODY. And they never would. We do not say that every hospital has to perform every procedure. Some hospitals would say they are not interested at that price regardless. Fine.

But, again, the dynamic model that you have to look at is that when you talk about access or anything else, hospitals will have pressures and resources shift, as they do in the private sector. And the access problem, what is a problem today, becomes vitiated tomorrow or the next day as resources shift around to take account of the market that is out there.

Ms. McCARTHY. I think we both face a challenge, because I think that challenge is not only to come in with a way of paying for services that are needed that is an efficient way to pay for it. But I truly believe you have got and we have got to attend to the access issue.

Again, is anything totally unworkable? Of course not. Are we looking at alternatives? Yes, we are. But it is just not going to be quite that simple as putting a single bid out and expecting that the Medicare beneficiaries' needs are going to be met.

Mr. MOODY. Well, need is a very elusive and subjective term.

Ms. McCARTHY. That is true.

Mr. MOODY. I need my own elevator in this building, but I am not going to get one because it would be too expensive. The word "need" can cover a multitude of sins. It can justify almost anything.

Ms. McCARTHY. Expressed need, then, demand. I mean, just even what we are facing in a system.

Mr. MOODY. Well, demand, when someone else is paying for the elevator, my need is very, very strong. That is what we have, a third-party payment problem. And demand, expressed demand is not a realistic measurement of what we should do because someone else is picking up the freight.

Ms. McCARTHY. Other countries have chosen to go about this in a rationing mode. They have chosen to simply say that people over certain ages or people who live certain life styles simply do not have available to them government paid for care.

Mr. MOODY. That is not a market system either. I am talking about a market-driven system.

Ms. McCARTHY. A lot of people fall through the cracks in the market.

Mr. MOODY. Well, they do. You know, we ration food in the private market which is an essential to life. We ration it through the market system. Then we have pickups for people who fall through the cracks. But we let the market drive the system predominantly because we know that is the most efficient way of having demand meet supply and at the lowest possible cost.

Ms. McCARTHY. Then the AHA really has supported the market base factors. We recognize, however, that when you are dealing with health care what you are most likely to end up with is something that is market but not a hundred percent market. I am simply saying that is a reality. I am saying our position as the AHA is, in fact, to favor the introduction of marketplace forces to the fullest extent possible.

When I say that, I find myself here speaking today with the same discomfort that—watching the discomfort over a margin. If we really believed in the marketplace, we would not care what a margin is or was. The problem is that we are dealing with a Gov-

ernment health care program. So we want to say market, and then we do not want to really live market either.

Chairman STARK. Doctor, I think honestly that the American Hospital Association's testimony as an association is less than useless to the committee. It obviously represents all the hospitals and, therefore, is not in a position to pick and choose among its members, which may be the need. If occupancy rates drop to some level, the obvious choice or anybody, whether it is of a controlled system or a market system, is we have got over capacity.

It seems to me that there is no more hope that the American Hospital Association politically could agree to that and maintain the support of its membership anymore than members of Congress could agree to close hospitals in their own district. So we both have political problems.

You have presented testimony which is a monument to obtusity, and it flops back and forth. It wants prices but it wants adjustments. Those things do not fit.

If in the future the American Hospital Association wants to participate in this, it is going to have to make some decisions as difficult as ours, which may mean that some of your members are going to go broke. Or we are going to have a completely controlled system. You cannot exist both ways.

Those are just redundancies which are not a matter of my choice or anybody else's. They cannot exist together. We cannot protect the inefficient and save money. It just does not work.

So I would hope in the future that you be prepared to make some choices. It cannot always be just more for everyone. We may have to start to say these are the ones. Maybe you could help us by identifying which ones should close. That may be the answer, but that is going to come if we go down this road in a price system. It is an inevitable result.

Ms. MCCARTHY. Mr. Chairman, if I may.

Chairman STARK. Yes.

Ms. MCCARTHY. The Medicare program—and the PPS payment system itself—has not been allowed to exist more than a year before we would change it, one piece of it, another piece of it, a third piece of it, a fourth piece. We were asked to try to evaluate the changes that were being proposed this year in the program and try to provide you with something that was reality based by the figures that were available so that you would have at least that to look at some of the proposals against.

Now, if you say to me, Carol, what do you think hospitals rightfully should receive in an update factor? What that testimony says is if we are not looking to cut a program, not because it ought to be cut but because we have a Federal budget deficit to meet, you can in the fourth year, as we move to national rates, you can honestly say that the law, when it called for market basket, was an appropriate law.

The last time we met when Hal Cohen, who ran the Maryland Rate Setting Commission, sat here, he said the tightest kinds of updates you give in a highly regulated system is just market basket no more. That is all that testimony says. It tries to set forth why that is true in the fourth year going into the fifth.

If there is anything that is unclear in it, if there is any information that would be helpful to you, we will do our best to get it. It was not designed at all to obfuscate; it was designed to try to make clear the real world and how it fits into all we are hearing about cost reports and artifacts and all of those things out there. Does it look ahead to changing the system? No. But we are looking at that, and we would be willing to sit down and talk with you about that as we get more information on alternatives that appear to offer promise.

Chairman STARK. I am not sure what that says.

Ms. MCCARTHY. It is a commitment to you that there are alternatives, and we are looking hard at them and whether they are better than DRGs and whether they work better. We are looking at that, and we will share what we learn with you.

Chairman STARK. Fine. Thank you very much.

Ms. MCCARTHY. You are welcome.

[Whereupon, at 12:55, the hearing was adjourned.]

[Submission for the record follows:]

The National Association of Private
Psychiatric
Hospitals

1319 F Street, NW, Suite 1000, Washington, DC 20004 • 202-393-6700

March 31, 1987

The Honorable Fortney (Pete) Stark, Chairman
Subcommittee on Health
Committee on Ways and Means
1114 Longworth Building
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

On behalf of the National Association of Private Psychiatric Hospitals, the National Association of Children's Hospitals and Related Institutions, and the National Association of Rehabilitation Facilities, we respectfully request that this letter be included in the Committee on Ways and Means Health Subcommittee hearing record of April 1, 1987 on the subject of the update factor for PPS and PPS-exempt hospitals.

Last year, with your leadership, Congress clarified in the Sixth Omnibus Budget Reconciliation Act that the statutory provision which authorizes annual hospital payment increases, allows for separate rates of increase for PPS and PPS-exempt facilities. In addition, the Ways and Means Committee stated in its report accompanying the reconciliation bill, that "It is the committee's view that the criteria utilized to develop the update factor for PPS-exempt hospitals should be specific to the operation of these facilities." This year, Congress will determine the update factors for PPS and PPS-exempt hospitals. We would urge you and the Committee to recommend a separate rate of increase for PPS-exempt hospitals.

Each year since the beginning of the PPS, the Prospective Payment Assessment Commission (ProPAC) has recommended a separate rate of increase for PPS-exempt hospitals. This year, ProPAC will recommend a 4.4% increase for PPS-exempt hospitals, while the recommendation for DRG hospitals will be 2.3%. These ProPAC recommendations are consistent with the congressional requirement that the increase in FY88 hospital payments --PPS and PPS-exempt -- do not exceed market basket minus 2%. The reasons for the higher recommendation for PPS-exempt facilities are straightforward and logical.

First, the argument about rebasing does not apply to PPS-exempt hospitals. Under the per case cost limit, PPS-exempt hospitals receive an incentive payment (above actual current costs) of no more than 5% of the per case

target rate, while PPS hospitals retain the full difference between the DRG payment and their costs.

Second, PPS-exempt hospitals are not able to increase their revenue by upgrading the coding of cases (DRG Creep). In calculating an update factor for PPS-exempt facilities, there should be no adjustment for "DRG Creep" since excluded hospitals are not paid on a DRG basis. In past years, failure to establish a separate update factor has penalized PPS-exempt hospitals for a phenomenon that was not applicable to their payment system.

Third, the PPS hospital "site substitution" factor is inapplicable to PPS-exempt hospitals. The "site substitution" factor avoids double payment by reducing DRG payments where services originally included in the DRG fixed rate have been shifted to the outpatient sector. Since exempt hospitals are only paid for services actually provided there is no need for a "site substitution" adjustment.

Finally, both ProPAC and HCFA calculate separate market baskets for the different types of PPS-exempt hospitals because they recognize the different mix of inputs used in providing care in these specialized settings.

During the last few years, over 1700 hospitals have been negatively affected by the issuance of a single rate of increase for both PPS and PPS-exempt hospitals. Although the ProPAC recommendation moves toward a correction of this problem, it does not make up for the past shortfalls in the update factor for PPS-exempt hospitals. Therefore, it is imperative that Congress build upon its actions of last year and set a separate and adequate update factor for these hospitals. Although payments to PPS hospitals will increase in proportion to their update factor, the PPS-exempt hospitals' update factor affects only the target per case limits.

Your strong support and leadership in assuring fair and adequate payment for all hospitals is greatly appreciated. We look forward to working with you and the Committee in crafting a reconciliation bill that establishes a separate and fair Medicare payment increase for PPS-exempt hospitals.
On behalf of:

National Association of Private Psychiatric Hospitals, Robert L. Thomas, Executive Director
National Association of Children's Hospitals and Related Institutions, Robert H. Sweeney, President
National Association of Rehabilitation Facilities, Carolyn Zollar, General Counsel and Associate Director for Medical Rehabilitation

cc: Members, Ways and Means Health Subcommittee